JANUARY 1985	ASEPTIC MENINGITIS	ENCEPHALITIS	GIARDIA	HEPATITIS A	HEPATITIS B	MEASLES	MENING DISEASE	MUMPS	PERTUSSIS	RABIES ANIMALS	RUBELLA	SALMONELLA	SHIGELLA	TUBERCULOSIS	GONORRHEA
DISTRICT 1															
Daniels															
Phillips															
Roosevelt			2	1						1		1			2
Sheridan															
Valley															
DISTRICT 2															
Daniels										2					
Garfield															
McCone															
Prairie															
Richland								1							
Wibaux															
DISTRICT 3															
Custer							1			1					1
Fallon															1
Powder River															
Rosebud									4						3
Treasure									3						
DIST 4															
Blaine			1							1		1	2	1	1
Hill			1										2		3
Liberty			2												
DISTRICT 5															
Cascade				1								1	1	1	13
Chouteau												1	1	1	11
Glacier					1	8									3
Pondera															3
Teton															
Toole															
DISTRICT 6															
Fergus															
Golden Valley															
Judith Basin															
Musselshell															1
Petroleum															
Wheatland							1								
DISTRICT 7															
Big Horn															5
Carbon															
Stillwater															2
Sweet Grass															
Yellowstone												2	8		
DIST 8															
Broadwater															1
Jefferson															
Lewis & Clark			4	5											
DIST 9															
Gallatin			1												1
Meagher															
Park															1
DIST 10															
Carbon															
Lincoln															1
Sanders															
DISTRICT 10															
Flathead				2								3			2
Lake															
Lincoln															1
Sanders															
DIST 11															
Missoula			1	1								5	1		1
Ravalli															
Mineral															
DISTRICT 12															
Beaverhead															1
Deer Lodge															
Granite															
Madison															
Powell															
Silver Bow			1	1											
DISTRICT 13															
Cascade			12	5	3	8	2	1	11	0	12	7	2	1	51
Fergus			8	5	0	0	0	0	5	0	4	2	1	1	91
Judith Basin			1	1	0	0	0	1	14	0	8	2	5	1	88
Meagher			3	1	0	0	0	1	1	0	0	2	1	1	91
Wheatland			12	11	2	8	2	0	11	0	12	2	2	1	51
MONTHLY TOTAL			3	1	0	0	0	1	1	0	0	1	0	0	2
1984			8	5	3	8	2	1	5	0	4	2	1	1	91
TOTAL TO DATE			12	11	2	8	2	1	11	0	12	7	2	1	51
1984			8	5	3	8	2	1	5	0	4	2	1	1	91
1983			3	1	0	0	0	1	1	0	0	1	0	0	2

DELAYED REPORTS:

OTHER DISEASES Bacterial meningitis: S. Bow.1. Campylobacter: Deer Lodge.1; Missoula.2. Hepatitis, Non-A, Non-B: Missoula.1. Hepatitis, unspecified: Cascade.1. Influenza A: Beaverhead. 1; Gallatin.1; Missoula.4; Ravalli.1. Leptonella: Cascade.1. Psittacosis: Gallatin.1. Chlamydia pneumoniae: Big Horn.2. Parainfluenza, Type 3: Missoula.1. Roundworm: Phillips.1.

"Now That You Have a New Baby"

"Now That You Have a New Baby" is a film/videocassette program that presents the facts about infant immunization in a clear, compelling and even entertaining way. The film/videocassette formats are being made available at affordable prices to increase their use among those who help educate new parents. This program is adaptable to many settings--parents in the hospital, prenatal classes, in waiting rooms and in community health programs.

This program is available in 16mm film, 3/4" U-matic cassettes, or 1/2" VHS cassettes. The film sells for $75 per copy and the cassettes (regardless of size) sell for $40 per copy.

All three formats are available on a free-loan preview-for-purchase basis from Karol Media, 22 Riverview Drive, Wayne, N.J., 07470-3191, (201) 628-9111.

The development of this excellent program was sponsered by the American Academy of Pediatrics, American Hospital Association, and underwritten by a grant from Merck, Sharp and Dohme.

Montana State Department of Health and Environmental Sciences does not have this film in their film library; copies must be ordered from the above named distributor.

Pediatric Diphtheria-Tetanus (DT) Available from DHES in June

Pediatric DT will become available through DHES beginning sometime in June of this year to public health providers throughout the state. Those providers who are already receiving state vaccines will also be able to order this through the department. Those offices who wish to use the state DT vaccine should let us know of their needs in June.

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MONTANA MORBIDITY REPORT

Volume: 9:1 **Month of:** JANUARY 1985

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MONTANA MORBIDITY REPORT. Pub. No. 397830. Published monthly with an extra issue for March by the Health Services Division of the Department of Health and Environmental Sciences, Cogswell Building, Helena, Montana 59620. Distributed FREE to physicians, public health nurses, sanitarians, hospital administrators.

Respiratory virus activity - 1985

By Jim Brinker, Virologist

In early January 1985 influenza was isolated from a 10-year-old boy from Missoula. The strain involved was Influenza A H_3N_2 Phillipines/2/82 like. It is a descendant of the 1968 Hong Kong Flu. No more isolates were made in the next two weeks. In mid-January, more isolates were made from Missoula, Stevensville, Dillon and Bozeman. Influenza is still being isolated from all of these cities. A total of eleven isolates has been made so far. In addition, a serologic diagnosis was made on a person from Polson whose onset was in mid-January. The isolates have been from people 43 years or younger.

Other respiratory viruses have been active lately. They are adenoviruses (several strains) and Parainfluenza III. Noticeably absent in recent months has been Mycoplasma pneumoniae, which for several years has been prevalent year round.

ONE DAY REPORTABLE/COMMUNICABLE DISEASE WORKSHOPS SCHEDULED

By Judith Gedrose

Three sites around the state have been chosen for one day communicable/ reportable disease workshops. An agenda, reproduced below, has been prepared and the information necessary for CEARP approval will be submitted to Montana Nurses' Association.

The sessions are to be informal and discussion will be welcome. The content will be practical and examples of actual cases will be utilized. See below for names of sites and dates of workshops.

In order to prepare enough hand-out material and have meeting rooms of adequate size, it's important for you to pre-register. Please complete information requested in the coupon size area of the sheet below, clip off and return as soon as possible.

A G E N D A

COMMUNICABLE/REPORTABLE DISEASE WORKSHOP

9:00 - 10:00	Principles of Communicable Disease Control
10:00 - 10:15	BREAK
10:15 - 11:05	Montana Code Annotated and Administrative Rules of Montana related to Communicable Disease Control
11:05 - 12:00	Setting Priorities for Action
12:00 - 1:00	LUNCH
1:00 - 1:50	Working as a Multidisciplinary Team
1:50 - 2:10	BREAK
2:10 - 3:30	Prevention: The Major Objective

Pre-Registration -- Free Workshop/No Fee

Name _____ Work Phone # _____

Work Address _____ Title of Position _____

I will attend the workshop in:

_____ Missoula, March 22 at Missoula City/County Health Department.

_____ Great Falls, April 8 at Cascade County Convalescent Hospital Auditorium

_____ Circle, May 10 at McCone County Hospital Meeting Room

Return this form to the Nursing Bureau, Montana Department of Health and Environmental Sciences, Cogswell Building, Helena, MT 59620.
JG/kk/70-A

RABIES - January and February, 1985 Judith Gedrose, RN, MN, Epidemiologist

Rabies in domestic animals has caused concern so far this year in Montana. Discovery of the disease in domestic cats in Cascade and Lewis & Clark Counties and a rabid puppy in Rosebud County received considerable media coverage. Cattle positive on examination from Custer, Fallon, Fergus, Powder River, Roosevelt, and Valley Counties have raised the number of positive domestic animals to more than the usual yearly count in just two months. (March 14 a dog from Hays in Blaine County was found to be positive for rabies.)

Surveillance of endemic levels of rabies in wild animals is continually necessary to estimate the degree of virus availability in a geographic area. Such information can guide decisions for whether or not to treat persons exposed to animal bites and scratches occurring in that area. However, exposure to wild animals is usually rare, unless the animal is being kept as a pet, and then bites and scratches are usually confined to one person.

Domestic animals pose a greater concern and threat to humans than wild animals when they do become rabid, at least in the United States. Pets and livestock have close contact to humans before rabies is suspected and when they do exhibit the signs of disease, owners intimately care for them.

Rabies vaccination for domestic dogs and cats is the most effective means of preventing mass exposure of humans. "It is not economically feasible, nor is it justifiable from a public health standpoint, to vaccinate all livestock against rabies. Veterinary clinicians and owners of valuable animals may consider immunizing certain breeding stock located in areas where wildlife rabies is epizootic."[1] Persons handling livestock in epizootic areas should be reminded to consider rabies and take precautions whenever one of their animals is ill. Cats are more likely than dogs to expose humans if they become rabid, so cats should be vaccinated, as well as dogs.

Montana State Department of Health and Environmental Sciences personnel are available to assist Montana health care providers in determining the need for post-exposure rabies prophylaxis for exposed humans. The Department will provide at cost (plus shipping charges) Rabies Human Diploid Cell Vaccine and Rabies Immune Globulin. Phoning (406) 444-4740 will allow physicians, nurses and other health personnel to consult with MSDHES staff regarding rabies treatment questions. This number is a 24-hour answering service.

1. Morbidity & Mortality Weekly Report, December 30, 1983/Vol.32/No.51/p.673

- -

DTP Booster for School Entry will be Waived this Fall

Due to nationwide shortages of DTP vaccine and the moratorium on giving the 18-month and preschool booster doses, as requested by the Centers for Disease Control, preschool boosters of DTP will be waived for school entry this fall. The polio booster requirement is still in effect. The waiver for DTP vaccine will only be applicable to children under 7 years of age. (Those above 7 years of age can be given adult Td to fulfill the requirement.)

Our latest information is that DTP supplies will be back to normal levels again by December, 1985. When adequate supplies become available and the moratorium is lifted by the CDC, our department will notify schools and public health officials. There will then be a 30-day grace period, during which time all students will be expected to be brought into compliance with the school laws by receiving the normal DTP booster.

If you have any questions regarding this information, please call the Childhood Immunization Program at 444-4740.

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Volume: 9:2 Month of: February 1985

MONTANA MORBIDITY REPORT. Pub. No. 397830. Published monthly with an extra issue for March by the Health Services Division of the Department of Health and Environmental Sciences, Cogswell Building, Helena, Montana 59620. Distributed FREE to physicians, public health nurses, sanitarians, hospital administrators.

FEBRUARY 1985		ASEPTIC MENINGITIS	ENCEPHALITIS	GIARDIA	HEPATITIS A	HEPATITIS B	MEASLES	MENING. DISEASE	MUMPS	PERTUSSIS	RABIES, ANIMALS	RUBELLA	SALMONELLA	SHIGELLA	TUBERCULOSIS	GONORRHEA
DISTRICT 1	Daniels															
	Phillips															
	Roosevelt			1	6									4		5
	Sheridan															
	Valley				1						1					
DISTRICT 2	Dawson															
	Garfield															
	McCone										3					
	Prairie															
	Richland															
	Wibaux															
DISTRICT 3	Carter										4					
	Custer										2				1	1
	Fallon										1					
	Powder River										6					
	Rosebud														2	2
	Treasure															
DIST. 4	Blaine															2
	Hill			1									1	1		3
	Liberty															1
DISTRICT 5	Cascade								1		1		1	2		3
	Chouteau															
	Glacier			1			31									5
	Pondera						4									
	Teton															
	Toole						1									
DISTRICT 6	Fergus										2					
	Golden Valley															
	Judith Basin															
	Musselshell															
	Petroleum															
	Wheatland															
DISTRICT 7	Big Horn															3
	Carbon															
	Stillwater															
	Sweet Grass															1
	Yellowstone			2												15
DIST. 8	Broadwater															
	Jefferson															
	Lewis & Clark			1		1					1				1	4
DIST. 9	Gallatin			6		1										8
	Meagher															
	Park															
DISTRICT 10	Flathead	1			1	1							1		1	2
	Lake															1
	Lincoln												1			
	Sanders															
DIST. 11	Mineral															
	Missoula				1			1					1			6
	Ravalli															
DISTRICT 12	Beaverhead															1
	Deer Lodge															
	Granite															
	Madison															
	Powell															
	Silver Bow	1														
MONTHLY TOTAL	19 85	2	0	12	9	3	36	1	1	0	21	0	5	7	5	63
	19 84	1	0	2	6	4	0	1	2	1	7	0	4	0	1	81
	19 83	0	0	1	3	1	0	0	0	0	6	0	5	0	2	115
TOTAL TO DATE	19 85	1	0	24	20	5	44	3	2	0	32	0	17	14	7	116
	19 84	1	0	10	11	7	0	1	3	2	12	0	8	2	2	174
	19 83	0	0	4	4	1	0	0	0	1	20	0	13	0	5	203

DELAYED REPORTS:

OTHER DISEASES: Campylobacter: Missoula,6; Big Horn,1; Gallatin,1. Hepatitis Non-A,Non-B: Yellowstone,1. Hepatitis, unspecified: Flathead,1; Roosevelt,1. Influenza: regional activity. Mycoplasma: Yellowstone,1. Histoplasmosis: Yellowstone,1. Syphilis, secondary: Lake,1.

MARCH 1985	ASEPTIC MENINGITIS	ENCEPHALITIS	GIARDIA	HEPATITIS A	HEPATITIS B	MEASLES	MENING DISEASE	MUMPS	PERTUSSIS	RABIES, ANIMALS	RUBELLA	SALMONELLA	SHIGELLA	TUBERCULOSIS	GONORRHEA
DISTRICT 1															
Daniels															
Phillips															11
Roosevelt															
Sheridan													1		
Valley															
DISTRICT 2															
Dawson															
Garfield										1					
McCone															
Prairie															
Richland															
Wibaux															
DISTRICT 3															
Custer										2					
Custer										1					3
Fallon									1						
Powder River										4					
Rosebud										3					2 6
Treasure															
DIST 4															
Blaine						1				3			2		
Hill									1					1	
Liberty															
DISTRICT 5															3 5
Cascade												1			
Chouteau															
Glacier						72						2			1 10
Pondera															
Teton			1												
Toole															
DISTRICT 6															
Fergus															
Golden Valley															
Judith Basin															
Musselshell															
Petroleum															
Wheatland															
DISTRICT 7															2
Big Horn												1			
Carbon															
Stillwater															
Sweet Grass								1							
Yellowstone					1										20
DIST. 8															
Broadwater															
Jefferson			2												
Lewis & Clark					1										
DIST 9															
Gallatin			1									1			
Meagher															
Park															
DISTRICT 10															2
Flathead					2							1			2
Lake				1											
Lincoln															1
Sanders															
DIST 11															2
Mineral															5
Missoula			4									2			2
Ravalli															
DISTRICT 12															
Beaverhead															
Deer Lodge															
Granite															
Madison															
Powell															
Silver Bow	1														1
MONTH AT TOTAL 19 85	1	0	8	1	4	73	0	1	2	14	0	10	3	11	67
19 84	0	0	16	2	2	0	0	1	1	1	0	6	1	5	84
19 83	0	0	8	4	2	0	1	1	0	10	0	5	1	5	112
TOTAL TO DATE 19 85	2	0	12	21	9	117	3	3	2	46	0	22	17	18	163
19 84	1	0	18	13	9	0	1	4	2	15	0	14	3	7	254
19 83	0	0	12	8	3	0	1	1	1	30	0	18	1	10	315

DELAYED REPORTS.

OTHER DISEASES Bacterial meningitis: Cascade,1 Missoula,1; Silver Bow,1. Campylobacter:Lewis & Clark,2; Valley,1. Hepatitis, unspec.: Yellowstone,1. Legionella: Pondera,1.Yellowstone,1. Coccidiomycosis: Lewis & Clark,1. Tularemia: Missoula,1.

ANNUAL IMMUNIZATION STATUS REPORT OF MONTANA PUBLIC AND PRIVATE SCHOOL CHILDREN (HES-106)

A copy of the postcard below has been sent out to each school in Montana. The Montana Childhood Immunization Program hopes that this distribution method will encourage a greater, more timely response for the required information.

School Health Personnel:

Due to past confusion as to who should receive Annual Immunization Status Reports (orange form due Dec. 1), the Program has decided to notify each school that these forms will be available at the County Superintendent's office. It will be the responsibility of each school to pick up needed forms there.

Each year we receive calls and letters from schools who have lost, misplaced, or did not receive these reports. Since previous distribution methods have apparently failed, each school is now asked to obtain report forms from your County Superintendent of Schools.

Thank you for your cooperation in making this survey complete.

Sincerely,

M. Richard Nelson, Program Manager
Montana Childhood Immunization Program
Cogswell Building C-305
Helena, MT 59620

444-4740

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MONTANA MORBIDITY REPORT
THE GREAT SEAL OF THE STATE OF MONTANA

Volume: 9:4 Month of: March 1985

MONTANA MORBIDITY REPORT. Pub. No. 397330. Published monthly with an extra issue for March by the Health Services Division of the Department of Health and Environmental Sciences, Cogswell Building, Helena, Montana 59620. Distributed FREE to physicians, public health nurses, sanitarians, hospital administrators.

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MEASLES - MONTANA - 1985

M. Richard Nelson, Immunization Program Manager

From January 4 to March 22, 119 confirmed cases of measles were identified in Blaine, Glacier, Pondera, and Toole counties. All but two met the clinical case definition of measles -- generalized rash lasting three or more days; fever (101°F or higher, if measured); and at least one of the following symptoms: cough, coryza, conjunctivitis. Twenty-two cases have been sero-confirmed, including one of the cases which did not meet clinical case definition.

One-hundred and three (86%) were on the Blackfoot Reservation (103/82% in Browning), seven (5.8%) in Cut Bank, and three (2.5%) in East Glacier. One-hundred and thirteen (95%) were in Glacier County. Toole County (Shelby 2, Sunburst 1) had three cases; Pondera County (Brady) had one case; Blaine County (Harlem, Chinook) had two cases.

The age distribution of cases is as follows: ≤15 months = 33 (28%); 16 months to 4 years = 15 (13%); 5-19 years = 68 (57%); ≥20 years = 3 (2%).

Seventy-four (62%) of the cases have a history of adequate measles vaccination (live measles vaccine given on or after the first birthday; at least two weeks prior to rash onset). Fourteen of these were vaccinated at 12-14 months of age.

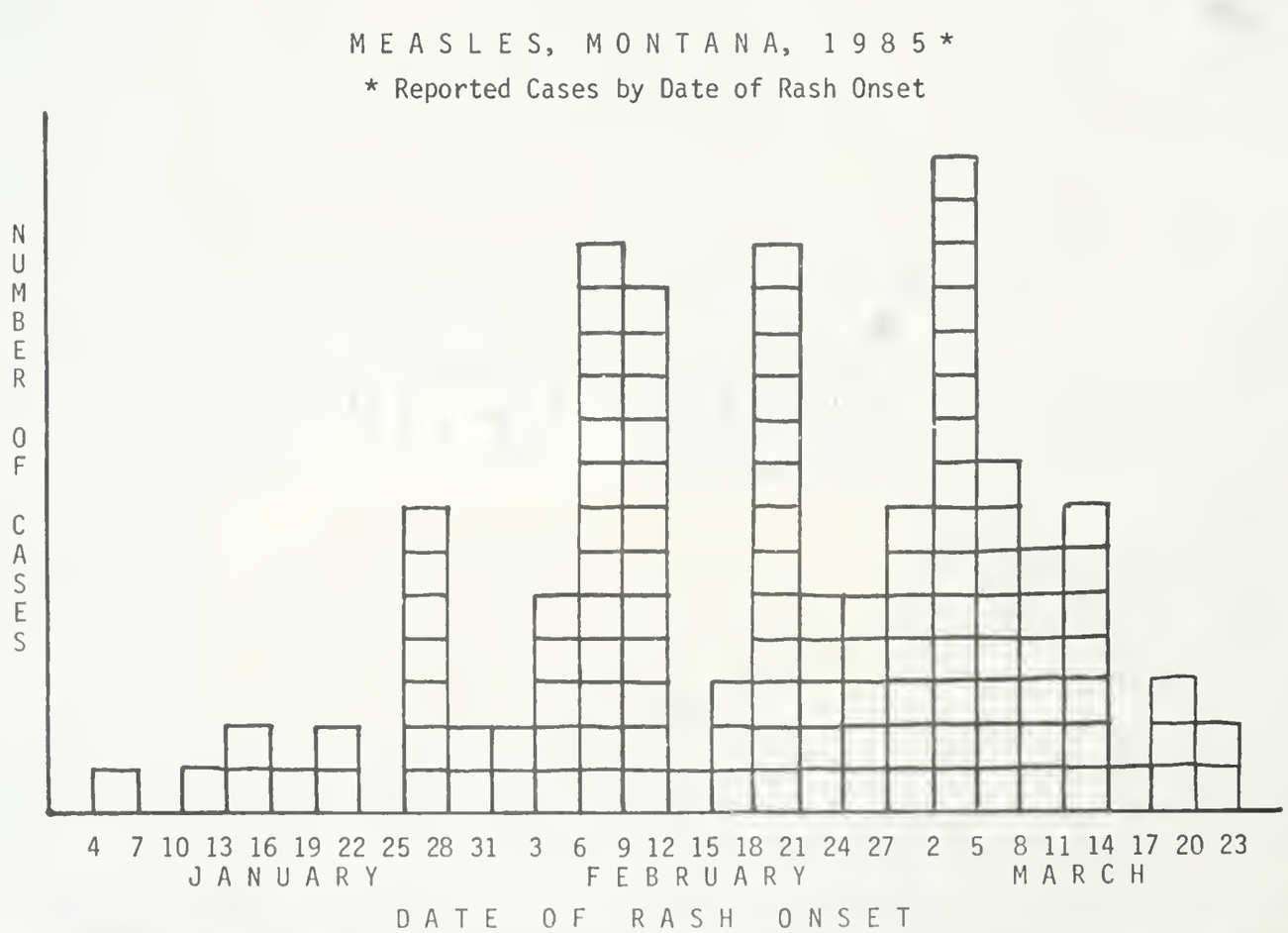
With regard to complications, two cases were hospitalized (one for 11 days and the other for two days) with pneumonia. Four additional cases had pneumonia, but were not hospitalized and 20 cases developed otitis media as a complication.

Forty-five cases were not adequately vaccinated due to being: 1) under 15 months of age, 2) exempt from immunization for medical or religious reasons, or 3) born before 1957. Seventy-four (62%) of the cases were adequately vaccinated on or after 12 months of age.

One-hundred and fourteen (96%) of the cases are considered by definition to be non-preventable. A case is considered to be non-preventable if measles illness occurs in a person: 1) less than 16 months of age, 2) born before 1957, 3) who has adequate evidence of immunity, 4) who has a medical contraindication to receiving vaccine, or 5) who has a religious or philosophical exemption under Montana law.

The index-patient was a seven-year-old girl from Browning with rash illness onset January 4, 1985. She had traveled to California with her family on December 16-28, and to Oregon on December 28-30. There were three reported cases of measles in Los Angeles during the time when she was there (December 16-22). The index case spread the disease to her sister, a cousin, a schoolmate, and a seven-month-old child.

Even though these cases have been primarily confined to the three counties of Glacier, Pondera, and Toole, a high index of suspicion for measles should continue throughout the state during the remaining school months. If a rash illness is seen or reported, it should be determined if it meets the clinical case definition addressed above and reported to local health officials and the Childhood Immunization Program of the Department of Health and Environmental Sciences at 444-4740.


MEASLES, MONTANA, 1985*
* Reported Cases by Date of Rash Onset
NUMBER OF CASES
4 7 10 13 16 19 22 25 28 31 3 6 9 12 15 18 21 24 27 2 5 8 11 14 17 20 23
JANUARY
FEBRUARY
MARCH
DATE OF RASH ONSET

A Case-Control Study for the Disease Infant Botulism

Judith Gedrose, RN, MN, State Epidemiologist

Centers for Disease Control (CDC) will conduct a case-control study nationwide to learn more about the risk factors associated with acquiring infant botulism. The disease's clinical spectrum will also be scrutinized in this study.

The Department has agreed to cooperate in the study. When we receive a report from you of a case of infant botulism, we will contact Dr. John Spika, Enteric Diseases Branch, CDC. CDC will contact the Montana physician in charge of the case and request more information. CDC will also request permission to contact the parents of the case to administer a questionnaire. A control from the Montana hospital in which the case was hospitalized will be chosen and the parents of that child asked to complete a questionnaire also.

Your participation will be greatly appreciated.

Tuberculosis Control Law Strengthened

Judith Gedrose, RN, MN, State Epidemiologist

A bill signed into law by the governor during this legislative session strengthens the control measures health departments can implement regarding tuberculosis case follow-up. Montana Code Annotated, Title 50, Chapter 17 contains the statute entitled Tuberculosis Control.

The changes were presented to the legislature in house bill 119 (HB 119) which was proposed by the Department and sponsered by Representative Joan Miles.

The former version of the statute was written when tuberculosis patients received most of their care in a hospital, specifically Galen (now Montana State Hospital, Galen Campus). The changes in the law clarify the right of health personnel to follow a tuberculosis case from the time of diagnosis to completion of adequate treatment, regardless of the setting in which the case resides.

Test for Detecting HTLV-III Antibody in Donated Blood Now in Use

Judith Gedrose, RN, MN, State Epidemiologist

March 3, 1985 the Food and Drug Administration approved several tests for use in screening donated blood for the presence of HTLV-III antibody. The presence of HTLV-III virus and its antibody has been shown repeatedly in body fluids of Acquired Immune Deficiency Syndrome cases. Over 100 U.S. citizens have developed AIDS when their only risk factor for the syndrome was via donated blood. Use of the test should greatly reduce the likelihood of AIDS occurring after receipt of blood in otherwise non-high-risk persons.

Montana State Department of Health and Environmental Sciences (MSDHES) has received notice that a grant submitted by the Department for funds to assure an alternate test site has been approved. The 90-day award will allow the MSDHES microbiology laboratory to begin doing the HTLV-III/LAV antibody tests. Counselling training will also be purchased with the funds.

The grants are made to states to ensure sites other than blood banks are providing testing. Health care professionals should discourage persons from donating blood to attempt to learn their HTLV-III antibody status. The tests available at this time are not intended for diagnostic use, but if a person can not be dissuaded as to the value of s/he having the test done, s/he should have a guided referral to her/his physician who may wish to submit a specimen to MSDHES for testing. Assistance in counselling HTLV-III antibody positive or high risk patients will also be available from MSDHES to local health departments, blood banks, and/or any other health provider requesting it.

The Department has much material regarding HTVL-III testing and Acquired Immune Deficiency Syndrome (AIDS). We would like to share this information with health care providers and high-risk groups.

Copies of a publication by the Association of State and Territorial Health Officials Foundation (ASTHO), Guide to Public Health Practice: HTLV-III Screening in the Community, are available. This 13-page document contains recommendations for dealing with the HTLV-III test and high-risk individuals. The guidelines are very similar to the Department's plans for responding. Address your requests for the booklet or any HTLV-III/AIDS assistance to:

Judith Gedrose, RN, MN
Nursing Bureau
Cogswell Building
Helena, MT 59620
Phone: 444-5580

As of April 15, AIDS is reportable as a Category A disease. A case must be reported to the health department within 24 hours of diagnosis. To ensure confidentiality, we ask you to use an identifier other than the patient's name when reporting. We will be requesting detailed information regarding the clinical case via a CDC form. Positive HTLV-III antibody tests must also be reported according to Administrative Rules of Montana 16.28.201. Again, we would like you to NOT use the patient's name, but choose another identifier for these reports.

DTP Vaccine Moratorium on 4th and 5th Doses Has Been Lifted - Pediatric DT Will Be Available in Late June

The DTP shortage has finally caught up with nationwide demand and the moratorium on the 18-month and preschool boosters has been lifted. The Immunization Program asks that each provider assess their needs for DTP vaccine to recall those children whose DTP boosters had been waived. Order vaccine to cover present needs and recall for DTP immunizations.

Pediatric DT has been ordered and will be available in late June. Those providers who have already sent in their DT orders should be assured that orders will be shipped upon arrival of the Immunization Program supply.

There will be no vaccine shipped to providers during the months of July and August. Please be certain that you have an adequate supply of each of the vaccines to carry your pregram into September, 1985. Thank you.

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MONTANA MORBIDITY REPORT

Volume: 9:5 Month of: APRIL 1985

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v.9#5
APR 1985

MONTANA MORBIDITY REPORT. Pub. No. 397830. Published monthly with an extra issue for March by the Health Services Division of the Department of Health and Environmental Sciences, Cogswell Building, Helena, Montana 59620. Distributed FREE to physicians, public health nurses, statisticians, hospital administrators.

	APRIL 1985	ASEPTIC MENINGITIS	ENCEPHALITIS	GIARDIA	HEPATITIS A	HEPATITIS B	MEASLES	MENING. DISEASE	MUMPS	PERTUSSIS	RABIES, ANIMALS	RUBELLA	SALMONELLA	SHIGELLA	TUBERCULOSIS	GONORRHEA
DISTRICT 1	Daniels										2					
	Phillips									1						
	Roosevelt				11						1			1		4
	Sheridan										1					
	Valley										2					
DISTRICT 2	Dawson										3					1
	Garfield															
	McCone															
	Prairie															
	Richland							1								
	Wibaux															
DISTRICT 3	Carter										1					
	Custer										1					
	Fallon										2					
	Powder River										3					
	Rosebud										1					
	Treasure															
DIST. 4	Blaine															
	Hill					1							2		1	6
	Liberty															
DISTRICT 5	Cascade												1			6
	Chouteau															
	Glacier						10									9
	Pondera						1				1					1
	Teton															
	Toole										2					
DISTRICT 6	Fergus										1		1			
	Golden Valley															
	Judith Basin										2					
	Musselshell															
	Petroleum															
	Wheatland															
DISTRICT 7	Big Horn			2												1
	Carbon															
	Stillwater															
	Sweet Grass															
	Yellowstone			1									1		1	9
DIST. 8	Broadwater															
	Jefferson															
	Lewis & Clark															2
DIST. 9	Gallatin			6									1			1
	Meagher															
	Park														1	
DISTRICT 10	Flathead															5
	Lake				1				1				1			
	Lincoln															
	Sanders															
DIST. 11	Mineral															
	Missoula			7	1	1							1			8
	Ravalli				1		8									
DISTRICT 12	Beaverhead			1												
	Deer Lodge															
	Granite												1			
	Madison															
	Powell						1									
	Silver Bow			1												3
MONTHLY TOTAL	19 85	0	0	18	14	2	20	1	1	1	23	0	9	1	3	56
	19 84	2	0	8	8	0	0	0	0	0	22	0	6	2	3	91
	19 83	April 1983 statistics will be reported with May 1983 statistics - combined --														
TOTAL TO DATE	19 85	2	0	50	35	11	137	4	4	3	69	0	36	18	21	239
	19 84	3	0	26	21	9	0	1	4	3	37	0	20	5	10	349
	19 83	April 1983 statistics will be reported with May 1983 statistics - combined --														

DELAYED REPORTS:

OTHER DISEASES: Bacterial meningitis: Lake,1; Lewis & Clark,1; Fallon,1. Campylobacter: Gallatin,2; Missoula,2; Yellowstone,1. Hepatitis, Non-A,Non-B: Flathead,1; Unspecified: Sanders,1. Legionella: Cascade,1.

NEW Recommendations for Protection Against Viral Hepatitis (excerpt MMWR June 7, 1985 / Vol. 34 / No. 22)*

The following statement updates all previous recommendations on use of immune globulins for protection against viral hepatitis (MMWR 1981;30:423-35) and use of hepatitis B vaccine and hepatitis B immune globulin for prophylaxis of hepatitis B (MMWR 1982;31:317-28 and MMWR 1984;33:285-90).

INTRODUCTION

The term "viral hepatitis" is commonly used for several clinically similar diseases that are etiologically and epidemiologically distinct (1). Two of these, hepatitis A (formerly called infectious hepatitis) have been recognized as entirely separate entities since the early 1940s and can be diagnosed with specific serologic tests. The third, currently known as non-A, non-B hepatitis, is probably caused by at least two differnt agents, and lacking specific diagnostic tests, remains a disease diagnosed by exclusion. It is an important form of acute viral hepatitis in adults and currently accounts for most post-transfusion hepatitis in the United States. An epidemic type of non-A, non-B hepatitis, which is probably spread by the fecal-oral route and is different from the types seen in the United States, has been described in parts of Asia and North Africa (2).

A fourth type of hepatitis, delta hepatitis, has recently been characterized as an infection dependent on hepatitis B virus. It may occur as a coinfection with acute hepatitis B infection or as superinfection of a hepatitis B carrier (3).

References: 1. Francis DP, Maynard JE. The transmission and outcome of hepatitis A, B, and non-A, non-B: a review. Epidemiol Rev 1979;1:17-31.
2. Maynard JE. Epidemic non-A, non-B hepatitis. Seminars in Liver Disease 1984;4:336-9.
3. Rizzetto M. The delta agent. Hepatology 1983;3:729-37.

*(The above excerpt is inserted here to call your attention to the update and can be found in its entirety in the above referenced MMWR.)

NEW CCDM NOW AVAILABLE

The 14th (1985) edition of Control of Communicable Diseases in Man (CCDM) is now available from the American Public Health Association. This edition outlines over 150 diseases, including AIDS, and provides additional information on the relationship between the formation of tumors and specific causative agents, e.g., hepatocellular carcinoma and hepatitis B. CCDM is available in 13 languages, including Spanish, for $9.00 from:

Publications
American Public Health Association
1015 15th Street
Washington, D.C. 20005

Texas Preventable Disease News

MAY 1985

	DISTRICT 1				DISTRICT 2					DISTRICT 3						DISTRICT 4	DIST. 5					DISTRICT 6						DISTRICT 7					DIST. 8	DIST. 9		DISTRICT 10				DISTRICT 11		DISTRICT 12						TOTAL TO DATE	MONTHLY TOTAL
	Daniels	Phillips	Roosevelt	Sheridan	Valley	Dawson	Garfield	McCone	Prairie	Custer	Carter	Fallon	Powder River	Rosebud	Treasure	Wibaux	Blaine	Hill	Liberty	Cascade	Chouteau	Glacier	Pondera	Teton	Toole	Fergus	Golden Valley	Judith Basin	Meagher	Musselshell	Petroleum	Wheatland	Big Horn	Stillwater	Sweet Grass	Yellowstone	Broadwater	Jefferson	Lewis & Clark	Gallatin	Madison	Park	Lake	Lincoln	Sanders	Flathead	Granite	Powell	Silver Bow		
ASEPTIC MENINGITIS																		1																1													1	5	1	8
ENCEPHALITIS																																																0	0	0	0
GIARDIA													1									1																	1									1	9	2	10
HEPATITIS A			3																														1							2			2					21	2	44
HEPATITIS B																	1																															1	0	12
MEASLES																																						1				2							0	0	140
MENING. DISEASE																																																0	0	4
MUMPS																																											1						0	1	5
PERTUSSIS																																																13	0	16
RABIES, ANIMALS				2	3		4		1		1		1	1	1					6						1																					29	11	98
RUBELLA																																																0	0	0
SALMONELLA																	2					3													2							1						11	3	36
SHIGELLA			1																																													1	0	23
TUBERCULOSIS																		2				2													1				1									2	2	5
GONORRHEA			2										4				1	6		6		7							1					1				1		1						2	42	1	1

DELAYED REPORTS Tularemia: Missoula,1. (April)

OTHER DISEASES Bacterial meningitis: Gallatin,1; Missoula,1; Yellowstone,1. Campylobacter: Gallatin,1; Missoula,1; Valley,1. Lyme: Missoula,1. Rocky Mtn. Spotted Fever: Custer,1; Golden Valley,1. Tularemia: Big Horn,2.

MONTANA MORBIDITY REPORT
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POLYSACCHARIDE VACCINE FOR PREVENTION OF HAEMOPHILUS INFLUENZAE TYPE B DISEASE

INTRODUCTION

A polysaccharide vaccine* against invasive (bacteremic) disease caused by Haemophilus influenzae type b recently has been licensed in the United States. The purposes of this statement are to summarize available information about this vaccine and to offer guidelines for its use in the prevention of invasive H. influenzae type b disease.

HAEMOPHILUS INFLUENZAE DISEASE

H. influenzae is a leading cause of serious systemic bacterial disease in the United States. It is the most common cause of bacterial meningitis, accounting for an estimated 12,000 cases annually, primarily among children under 5 years of age. The mortality rate is 5%, and neurologic sequelae are observed in as many as 25%-35% of survivors. Virtually all cases of H. influenzae meningitis among children are caused by strains of type b (Hib), although this capsular type represents only one of the six types known for this species. In addition to bacterial meningitis, Hib is responsible for other invasive diseases, including epiglottitis, sepsis cellulitis, septic arthritis, osteomyelitis, pericarditis, and pneumonia. Nontypeable (noncapsulated) strains of H. influenzae commonly colonize the human respiratory tract and are a major cause of otitis media and respiratory mucosal infection but rarely result in bacteremic disease. Hib strains account for only 5%-10% of H. influenzae causing otitis media. In the United States, approximately one of every 1,000 children under 5 years of age develops systemic Hib disease each year, and a child's cumulative risk of developing systemic Hib disease at some time during the first 5 years of life is about one in 200. Incidence rates of Hib disease are increased in certain high-risk groups, such as Native Americans (both American Indians and Eskimos), blacks, individuals of lower socioeconomic status, and patients with asplenia, sickle cell disease, Hodgkin's disease, and antibody deficiency syndromes. Recent studies also have suggested that the risk of acquiring primary Hib disease for children under 5 years of age appears to be greater for those who attend day-care facilities than for those who do not (2,3).

HAEMOPHILUS b POLYSACCHARIDE VACCINE

The Hib vaccine induces an antibody response that is directly related to the age of the recipient; infants respond infrequently and with less antibody than do older children or adults. Improved responses are observed by 18 months of age, although children 18-23 months of age do not respond as well as those 2 years of age or older.

EFFECTIVENESS OF VACCINE

Among children 18-71 months of age, 90% protective efficacy (95% confidence limits, 55%-98%) in prevention of all forms of invasive Hib disease was demonstrated for the 4-year follow-up period. The vaccine was not efficacious in children under 18 months of age.

REVACCINATION

As with other polysaccharide vaccines, the shorter persistence of serum antibodies in young children given Hib vaccine, compared with adults, suggests that a second dose of vaccine may be needed to maintain immunity throughout the period of risk, particularly for children in the youngest age group considered for vaccination (those 18-23 months of age). A second injection following the initial dose is likely to increase the protective nation, although detectable in most vaccine recipients, are no longer significantly different from those in unvaccinated children of the same age.

RECOMMENDATIONS FOR VACCINE USE

1. Immunization of all children at 24 months of age is recommended.
2. Immunization of children at 18 months of age, particularly those in known high-risk groups, may be considered.
3. Immunization of individuals over 24 months of age who have not yet received Hib vaccine should be based on risk of disease.
4. Insufficient data are available on which to base a recommendation concerning use of the vaccine in older children and adults with the chronic conditions associated with an increased risk of Hib disease.
5. Vaccine is not recommended for children under 18 months of age.
6. Simultaneous administration of Hib and DTP vaccines at separate sites can be performed, because no impairment of the immune response to the individual antigens occurs under these circumstances.

SIDE EFFECTS AND ADVERSE REACTIONS

Polysaccharide vaccines are among the safest of all vaccine products. Only one serious systemic reaction has been reported thus far--a possible anaphylactic reaction that responded promptly to epinephrine. Mild local and febrile reactions were common.

PRECAUTIONS AND CONTRAINDICATIONS

The Hib vaccine is unlikely to be of substantial benefit in preventing the occurrence of secondary cases, because children under 2 years old are at highest risk of secondary disease. Because the vaccine will not protect against nontypeable strains of H. influenzae, recurrent upper respiratory diseases, including otitis media and sinustitis, are not considered indications for vaccination. Excerpted from M.M.W.R., May 10, 1985.

BUTTOCKS NO LONGER RECOMMENDED

A recommended route(s) of administration is included for each vaccine. The choice of route is based on prior clinical trials which demonstrated safety and efficacy. To avoid untoward local or systemic effects and ensure optimal efficacy of the immunization procedure, the practitioner should not deviate from the recommended route of administration.

Injectable vaccines should be administered in an area as free as possible of opportunity for a local neural, vascular, or tissue injury. In the past, the upper, outer quadrant of the buttocks was frequently selected as a site for immunization administration. This site is no longer recommended, except for large volume administration (e.g., gamma-globulin in some instances). Preferred sites include the anterolateral aspect of the upper thigh and the deltoid muscle of the upper arm. These areas should be used whether the vaccine is to be administered subcutaneously or intramuscularly. In most infants, the anterolateral aspect of the thigh will provide the largest muscle; therefore, it is the preferred site in this age group. In older children the deltoid mass has achieved sufficient size to offer a convenient site for intramuscular injection. An individual decision must be made for each child, based on the volume of the injected material and the size of the muscle into which it has to be injected. Many practitioners prefer to continue to use the anterolateral thigh muscles until well into childhood before switching to the deltoid muscle.

Intradermal injections are generally given on the volar surface of the forearm.

Syringes and needles for vaccine injections preferably should be disposable to minimize the opportunity for contamination; a separate needle and syringe should be used for each immunization. Needles and syringes should be disposed of in specially labeled containers to prevent accidental innoculation or theft.

For subcutaneous or intradermal injections, a 5/8" long, 25-guage needle is recommended; for intramuscular injections, a 1 to 1¼" long, 20- or 22-guage needle is recommended.

Recent studies on Hepatitis B vaccine and rabies vaccine also demonstrate that immunizations given in the gluteal muscle are not as efficacious. Reportable Disease Bulletin, March 1985, North Dakota.

NEW MALARIA PREVENTION RECOMMENDATIONS FOR TRAVELERS ‡

In the January 19 issue, we reported interim Centers for Disease Control recommendations for prevention of malaria in travelers. New, more specific, recommendations have now been issued for preventing chloroquine-resistant Plasmodium falciparum (CRPF) malaria. (1)

The new recommendations result from increasing concern over the safety of Fansidar (pyrimethamine-sulfadoxine) for malaria prophylaxis. Since 1982, when Fansidar was licensed, 20 cases of erythema multiforme, Stevens-Johnson syndrome, and toxic epidermal necrolysis have been reported in American travelers using the drug. Six of these were fatal. (The estimated risk of death is between 1/18,000 and 1/26,000 Fansidar users.) Other adverse reactions, including serum sickness, urticaria, exfoliative dermatitis, and hepatitis, have been reported.

The new recommendations emphasize personal protection measures and individualized decisions about chemoprophylaxis based upon risk of exposure to CRPF. The personal protection measures are most important between dusk and dawn, when the Anopheles mosquito feeds. They include remaining in well-screened areas, using mosquito netting, wearing clothes that cover most of the body, and using an insect repellent (N, N diethylmetatoluamide or deet is best.) Chloroquine alone is recommended for travelers to malarious areas without CRPF.* Fansidar should be used in addition to chloroquine only according to these geographic area-specific recommendations:

AFRICA: In some areas, the risk of malaria transmission is very high. Short term (3 weeks or less) travelers to African areas with CRPF* should use weekly chloroquine alone. They should be given one treatment dose (3 tablets) of Fansidar** to carry and to use if a febrile illness occurs where medical care is not available. (These persons should be advised to seek medical care as quickly as possible if febrile illness does occur.)

Long term travelers to CRPF-endemic areas should consider using combined chloroquine and Fansidar** for weekly prophylaxis. Expected living conditions, availability of medical care, and local malaria transmission patterns should be considered when evaluating the risks and benefits of Fansidar use. Possible alternatives to this regimen include amodiaquine (not available in U.S. but widely available in Africa) or doxycycline alone (100 mg daily - not to be used by pregnant women or children under age 8). Persons electing doxycycline should be warned of the potential for photosensitivity reactions.

OCEANEA: Malaria transmission risk is very high. The recommendations for Africa apply here.

CHINA AND SOUTHEAST ASIA: Malaria transmission risk is relatively lower, and occurs primarily in rural areas. Travelers who will visit only urban centers or who will have only daytime exposure to rural areas are not recommended to take malaria chemoprophylaxis. They should, however, observe personal protection measures and seek prompt medical attention if a febrile illness occurs. Travelers who will have outdoor exposure in rural, malarious areas during evening and nighttime hours should consider prophylaxis as for Africa.* In some areas of rural Thailand, resistance to both chloroquine and Fansidar has been reported. Special regimens for travelers there should be determined with consultation from the Health Division (229-5792).

SOUTH AMERICA: Malaria transmission risk here is low in urban areas, except in the interior Amazon basin and coastal areas of Ecuador. Recommendations described for China and Southeast Asia should be followed in South America.*

INDIAN SUBCONTINENT: Malaria transmission occurs in both urban and rural areas of Bangladesh, India, and Pakistan. Although CRPF is reported in many parts of these countries, it has generally been of low level and in areas not frequented by tourists. Chloroquine alone is, therefore, recommended for travelers to these countries. Personal protection against mosquito bites and seeking medical attention in the event of febrile illness are also advised.

---

* To determine the risk of malaria transmission and exposure to CRPF in a specific country, contact your local health department or the Health Division.

** Fansidar contains 25 mg pyrimethamine and 500 mg sulfadoxine in each tablet. The adult dose for prophylaxis is one tablet weekly. It should not be prescribed for persons with a history of reaction to either component drug.

REFERENCE

(1) Centers for Diseases Control: Revised recommendations for preventing malaria in travelers to areas with chloroquine-resistant Plasmodium falciparum. MMWR 1985;34:185-190, 195.

‡ Reprinted from Communicable Disease Summary of Oregon Health Division, Vol.34,No.12

Lab specimen handling forms from the DHES Microbiology Laboratory have increased in cost to $1.75 starting July 1, 1985.

Please contact the laboratory at 444-3444, if you have any questions.

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June 1985

New Recommendations of the Immunization Practices Advisory Committee (ACIP)

1. Smallpox Vaccine - Published in Morbidity Mortality Weekly Report (MMWR) June 14, 1985/Vol.34/No.23

   These revised ACIP recommendations on smallpox vaccine update the previous recommendations (MMWR 1980;29:417-20) to include current information on the changes in the International Health Regulations and the ending of distribution of smallpox vaccine to civilians. The basic recommendation is unchanged -- smallpox vaccine is only indicated for civilians who are laboratory workers occupationally exposed to smallpox or to other closely related orthopox viruses.

2. Prevention and Control of Influenza - Published in MMWR May 17, 1985/Vol.34/No.19

   These recommendations of the Immunization Practices Advisory Committee (ACIP) update for 1985-1986 the information on the vaccine and antiviral agent available for control of influenza (superseding MMWR 1984;33:253-66). Changes include addition of statements about: (1) the route of vaccine administration; (2) the use of amantadine in medical personnel during influenza A outbreaks; (3) the need to prepare contingency plans to expedite use of amantadine in aborting influenza A outbreaks among residents of institutions; and (4) reduction in the dosage of amantadine for older patients or persons with seizure disorders.

INDOCHINESE REFUGEE TUBERCULIN SKIN TEST STUDY — May 15, 1985 Memorandum - Department of Health & Human Services, Public Health Service, Centers for Disease Control, Division of Tuberculosis Control & Division of Quarantine — Snider/Farer, M.D.'s

From February to May of this year, 2500 Indochinese refugees at the Phillipine Refugee Processing Center (PRPC), Bataan, will have been skin tested one to three times with PPD tuberculin, and once with a nontuberculous mycobacterial (NTMB) antigen, as part of the Centers for Disease Control protocol to evaluate the high rate of apparent skin test conversions in this high-risk group.

Refugees who were volunteers in the study will begin arriving in the United States in June, and nearly all will be in the United States by September 30. Results of tuberculin tests given in the study will be attached to the Medical Examination of Visa Applicants Form (OF-157) accompanying each refugee. The results will appear as below:

We recommend that refugees for whom any of these tuberculin tests (not NTMB test) is recorded as 10mm or greater receive isoniazid preventive therapy according to Centers for Disease Control/American Thoracic Society recommendations. Note that a few of these refugees may have been started on isoniazid preventive therapy at the PRPC because of contact with cases of current tuberculosis disease; the preventive treatment starting date will be indicated on the OF-157. We recommend continuation of this treatment until a total of 12 months of drug ingestion is achieved.

Refugees who participated in this study fo not need to be tested again as part of the refugee health assessment in the United States. Until data from this study are analyzed, we recommend that other refugees be tuberculin skin tested only once as part of the refugee health assessment. Repeat tests in the United States should be limited to refugees who are found to be initially non-reactive to tuberculin when examined as contacts of cases newly diagnosed in the United States, (in accordance with usual contact examination procedures).

USPHS/CDC STUDY OF TUBERCULIN BOOSTING

5 TU PPD test results:

Date	Induration(mm)

10 mm or more should be interpreted to indicate past TB infection

This person (has ___)(has not ___) started INH preventive therapy.

INTRODUCING A BRIGHT NEW ADDITION TO OUR STAFF....

Barbara Meek, our new Public Health Advisor, arrived in Helena June 10th. She is the State of Montana's representative from the Centers for Disease Control (CDC) in Atlanta. She will be advisor/consultant in all areas of disease surveillance and control, including STD, TB, Immunization, and Environmental Health.

Barbara received her B.S. degree in biology and continued graduate work at Auburn University in Montgomery, Alabama. She has also done extensive coursework in epidemiology and management through CDC. Barbara was also the distinguished graduate from the U.S. Army School of Allied Health Sciences Clinical Specialist course.

Barbara was previously assigned as the STD Operations Manager and TB Program Manager in New Orleans, Louisiana. Prior to those assignments, she worked with the STD Program in Washington, D.C. This is her first assignment in the Northwest and her enthusiasm for Montana has won us over already.

In addition to her new duties with the Department of Health and Environmental Sciences, Barbara is an active member of the Army Reserves and serves as Chief Wardmaster. Her hobbies include: knife collecting, reading, and camping.

Welcome to Montana, Barbara!

| JUNE 1985 | TOTAL TO DATE 19 84 | TOTAL TO DATE 19 85 | MONTHLY TOTAL 19 84 | MONTHLY TOTAL 19 85 | DISTRICT 12: Silver Bow | Powell | Madison | Gravelly | Deer Lodge | Beaverhead | DIST 11: Missoula | Ravalli | Mineral | DISTRICT 10: Sanders | Lincoln | Lake | Flathead | Park | DIST. 9: Gallatin | Meagher | DIST 8: Lewis & Clark | Jefferson | Broadwater | DISTRICT 7: Yellowstone | Sweet Grass | Stillwater | Carbon | Big Horn | DISTRICT 6: Wheatland | Petroleum | Musselshell | Judith Basin | Golden Valley | Fergus | DISTRICT 5: Toole | Teton | Pondera | Glacier | Chouteau | Cascade | DIST 4: Liberty | Hill | Blaine | DISTRICT 3: Treasure | Rosebud | Powder River | Fallon | Custer | Carter | DISTRICT 2: Wibaux | Richland | Prairie | McCone | Garfield | Dawson | DISTRICT 1: Valley | Sheridan | Roosevelt | Phillips | Daniels |
|---|---|---

THE FACTS OF LICE*

IDENTIFICATION

The head louse (Pediculus Humanis Capitis) is a bloodsucking insect that lives on the scalp and hair of humans. After fertilization, adult females attach eggs (nits) firmly to the hair shaft near the scalp with a cement-like substance. Eggs hatch in 7-10 days and become egg-laying adults in 10 days. Head lice will live only 2 days off the host due to unsuitable temperature.

MODE OF TRANSMISSION

Individuals become infested by coming into close contact with an infected person, by wearing infested garments, by using infested combs and brushes, or by lying on infested carpets, beds or upholstered furniture that have recently been used by an infested person. Head lice require frequent blood meals and without such a meal will die in about 2 days. In general, environmental contamination (inside and out) is of little consequence in transmission.

DIAGNOSIS

Lice and nits are most commonly found at the nape of the neck and behind the ears. Unhatched eggs will be within ¼-inch of the scalp; nits ½-inch or more from the scalp are either dead or hatched.

TREATMENT

Pediculocides are not left on the hair long enough to kill all eggs though they rapidly kill nymphal and adult lice. Treatment should be repeated in 7-10 days to kill newly hatched eggs before they are capable of laying their own eggs and thus perpetuating the infestation. Some experts recommend retreatment only if there is evidence of reinfestation.

CONTROL

All contacts should be treated if evidence of active infestation is found. Additionally, all clothing and bed linens should be concurrently disinfected by washing in hot water and dried as hot as possible. Combs and brushes can be disinfected by soaking them in 2% Lysol solution for 1 hour. Furniture and carpet should be thoroughly vacuumed. Fumigation of rooms is not recommended since it is costly and its safety and efficacy have not been evaluated.

School children should be readmitted after their first treatment (even if all nits are not combed out.)

* Published by COLORADO DISEASE BULLETIN, Feb. 7, 1981; adapted from Oklahoma Communicable Disease Bulletin, Nov. 8, 1980.

JULY 1985	DISTRICT 1			DISTRICT 2			DISTRICT 3			DIST 4	DISTRICT 5			DISTRICT 6			DISTRICT 7			DIST 8	DIST 9	DISTRICT 10			DISTRICT 11	DISTRICT 12			TOTAL TO DATE	MONTHLY TOTAL
	Valley	Sheridan	Phillips	Roosevelt	McCone	Garfield	Custer	Fallon	Powder River	Hill	Toole	Teton	Pondera	Glacier	Chouteau	Cascade	Yellowstone	Sweet Grass	Stillwater	Carbon	Big Horn	Wheatland	Petroleum	Musselshell	Judith Basin	Golden Valley	Fergus	Treasure	Rosebud	Powder River	Carter	Wibaux	Richland	Dawson	Daniels	Sheridan	Glacier	Lincoln	Lake	Flathead	Missoula	Mineral	Granite	Deer Lodge	Powell	Madison	Gallatin	Silver Bow		
ASEPTIC MENINGITIS		1																			1									10	3
ENCEPHALITIS																														3	0
GIARDIA		1															2		1		2					1		1	2	18	4
HEPATITIS A		2																												15	3
HEPATITIS B										1							1									1				9	0
MEASLES																														0	0
MENING DISEASE																														3	0
MUMPS																														2	0
PERTUSSIS																	1				1									1	0
RABIES ANIMALS	1			1	2	2	1	1	2		1			1								2					1			13	0
RUBELLA																														4	0
SALMONELLA										2											1		1			1		1	2	20	2
SHIGELLA		5								2									2											7	1
TUBERCULOSIS											1						1				1									14	1
GONORRHEA																	12					1	1							652	106

DELAYED REPORTS:

OTHER DISEASES: Bacterial meningitis: Gallatin, 1; Lewis & Clark, 1; Missoula, 3. Campylobacter: Lake, 1; Missoula, 1. Colorado Tick Fever: Park, 1. Hepatitis, Non-A, Non-B: Yellowstone, 1. Hepatitis, unspecified: Gallatin, 1. Parenteritis: Lewis & Clark, 1. Tularemia: Big Horn, 2. Schistosomiasis: Lake, 2. Syphilis, secondary: Yellowstone, 1. 1986: Blaine, 1.

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Volume: 9:8 Month of: JULY 1985

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July 1985

INFLUENZA: Review of Last Season and Recommendations for Next Season

REVIEW OF LAST SEASON

A number of influenza specimen analyses and sero-studies were requested of the MOHES Microbiology Laboratory during the 1984-1985 season. The first positive isolate was recorded January 9, 1985, and identified as being Influenza A. A total of 294 cases were reported from October, 1984 through April, 1985.

IMMUNIZATION RECOMMENDATIONS FOR THE 1985-86 SEASON

The Immunization Practices Advisory Committee (ACIP) has issued its influenza vaccination recommendations for next season. (1) These are summarized here.

Target Groups for Vaccination

The traditional vaccination target groups (the elderly and persons with certain chronic diseases) have been further classified on the basis of priority by the ACIP to encourage special efforts to vaccinate those who may benefit the most:

"1. Groups for which active, targeted vaccination efforts are most necessary are:

   a. Adults and children with chronic disorders of the cardiovascular or pulmonary systems that are severe enough to have required regular medical follow-ups or hospitalization during the preceding year.

   b. Residents of nursing homes and other chronic-care facilities (e.g., institutions housing patients of any age with chronic medical conditions).

2. Although not proven, it is reasonable to believe that medical personnel can transmit influenza infections to their high-risk patients while they are themselves incubating infection, undergoing subclinical infection, or working despite the existence of mild symptoms. In many winters, nosocomial outbreaks of influenza are reported. The potential for introducing influenza to high-risk groups, such as patients with severely compromised cardiopulmonary or immune systems of infants in neonatal intensive-care units, should be reduced by vaccination programs targeted at medical personnel. Therefore, physicians, nurses, and other personnel who have extensive contact with high-risk patients (e.g., primary-care and certain specialty clinicians and staff of intensive-care units) should receive influenza vaccination annually.

3. After considering the needs of the above two targeted groups, high priority should also be given to organizing special programs making vaccine readily available to persons at moderately increased risk of serious illness compared with the general population.

   a. Otherwise healthy individuals over 65 years of age.

   b. Adults and children with chronic metabolic diseases (including diabetes mellitus), renal dysfunction, anemia, immunosuppression, or asthma that are severe enough to require regular medical follow-ups or hospitalization during the preceding year." (1)

The ACIP encourages institutions for the aged or chronically ill to seek to vaccinate at least 80% of their residents. Hospitals and doctors are encouraged to seek a similar goal for vaccinating persons with severe cardiopulmonary disorders. Physicians are further encouraged to offer the vaccine to any persons who wish to reduce their chances of acquiring influenza infection. (1)

Vaccine Composition

The hemagglutinin antigen compositinn of the vaccine for the 1985-86 season will be identical to that for the past season: A/Chile/83 (H1N1), A/Philippines/82 (H3N2), and B/USSR/83. In spite of the fact that the two years' vaccines are identical, a history of vaccination for the 1984-85 season does not preclude the need to be revaccinated for the 1985-86 season. (Immunity is thought to decline during the year following vaccination.) Also, last season's vaccine should not be used after its June 30, 1985, expiration date.

Vaccine Administration

The specific recommendations for vaccine administration are summarized in Table 1. Special attentinn should be paid to the footnotes regarding use of split virus vaccine in children, injection site, and concomitant use of vaccine with pneumococcal vaccine.

TABLE 1. Influenza vaccine* dosage by age of patient — United States, 1985-1986 season

Age group	Product†	Dosage§	No. doses	Route¶
6-35 mos	Split virus only	0.25 ml	2**	IM
3-12 yrs	Split virus only	0.5 ml	2**	IM
> 12 years	Whole or split virus	0.5 ml	1	IM

*Contains 15 µg each of A/Chile/83(H1N1), A/Philippines/82(H3N2), and B/USSR/83 hemagglutinin antigens in each 0.5 ml. Manufacturers include Parke-Davis (Fluogen® split), Squibb-Connaught (Fluzone® whole or split), Wyeth Laboratories (Influenza Virus Vaccine, Trivalent split). Manufacturer's phone numbers to obtain further product information are: Parke-Davis—(800) 223-0432, Squibb-Connaught—(800) 822-2463, Wyeth—(800) 321-2304.

†Because of the lower potential for causing febrile reactions, only split (subvinon) vaccine should be used in children. Immunogenicity and reactogenicity of split and whole virus vaccines are similar in adults when used according to the recommended dosage.

§Pneumococcal vaccine and influenza vaccine can be given at the same time at different sites without an increase in side effects, but it should be emphasized that, whereas influenza vaccine is given annually, pneumococcal vaccine should be given only once to adults. Detailed immunization records should be provided to each patient to help ensure that additional doses of pneumococcal vaccine are not given.

¶The recommended site of vaccination is the deltoid muscle for adults and older children. The preferred site for infants and young children is the anterolateral aspect of the thigh musculature.

**Four weeks or more between doses, both doses recommended for maximum protection. However, if the individual received at least one dose of any influenza vaccine recommended from 1978-1979 to 1984-1985, one dose is sufficient.

Contraindications and Precautions

Influenza vaccine should not be administered to any person with a history of anaphylactic sensitivity to eggs. Persons with febrile illnesses should not be vaccinated until their temporary symptoms have abated. The vaccine is generally considered safe for use during pregnancy. Nevertheless, if vaccine is to be given to a pregnant woman, waiting until after the first trimester is a reasonable precaution for minimizing any theoretical concern about teratogenicity.

Use of Amantidine

The ACIP also offered recommendations for use of amantadine for short term prophylaxis during an influenza A outbreak, as an adjunct to late immunization of high risk individuals, for medical personnel, and to supplement vaccine protection in persons with impaired immune response. These will be presented in detail in the CD Summary next fall.

REFERENCE

(1) Centers for Disease Control: Recommendations of the Immunizatinn Practices Advisory Committee (ACIP) Prevention and Control of Influenza, MMWR, May 17, 1985; 34:261-268, 273-275.

ORDER INFLUENZA VACCINE NOW

To be assured of receiving enough influenza vaccine to use during the early fall, one needs to order early from the distributor. Official health agencies (county health departments and their sub-units) may purchase the vaccine at State term contract prices. Wyeth laboratories has the term contract and a vial of Influenza vaccine can be purchased @ $17.95. (10 does/vial, minimum order $100). Contact Wyeth at the following address:

Wyeth Laboratories
P. O. Box 5609
Kent, WA 98064-5609
Phone: (800) 336-8725

You must state the following term contract number 957-85-J to utilize the term contract.

--Excerpted from COMMUNICABLE DISEASE SUMMARY, May 25, 1985, Vol. 34, No. 11, Oregon Health Division

Excerpted from: Morbidity and Mortality Weekly Report, Vol. 34, No. 22, June 7, 1985

Recommendations for Protection Against Viral Hepatitis

INTRODUCTION

The term "viral hepatitis" is commonly used for several clinically similar diseases that are etiologically and epidemiologically distinct[1]. Two of these, hepatitis A (formerly called infectious hepatitis) and hepatitis B (formerly called serum hepatitis) have been recognized as separate entities since the early 1940's and can be diagnosed with specific serologic tests. The third, currently known as non-A, non-B hepatitis, is probably caused by at least two different agents, and lacking specific diagnostic tests, remains a disease diagnosed by exclusion. It is an important form of acute viral hepatitis in adults and currently accounts for most post-transfusion hepatitis in the United States. An epidemic type of non-A, non-B hepatitis, which is probably spread by the fecal-oral route and is different from the types seen in the United States, has been described in parts of Asia and North Africa (2).

A fourth type of hepatitis, delta hepatitis, has recently been characterized as an infection dependent on hepatitis B virus. It may occur as a coinfection with acute hepatitis B infection or as superinfection of a hepatitis B carrier[3].

Approximately 21,500 cases of hepatitis A, 24,300 cases of hepatitis B, 3,500 cases of non-A, non-B hepatitis, and 7,100 cases of hepatitis type unspecified were reported in the United States in 1983. Most cases of each type occur among young adults. Since reporting from many localities is incomplete, the actual number of hepatitis cases occurring annually is thought to be several times the reported number.

IMMUNE GLOBULINS

Immune globulins used in medical practice are sterile solutions of antibodies (immunoglobulins) from human plasma. They are prepared by cold ethanol fractionation of large plasma pools and contain 10%-18% protein. In the United States, plasma is primarily obtained from professional donors. Only plasma shown to be free of hepatitis B surface antigen (HBsAG) is used to prepare immune globulins.

Immune globulin (IG) (formerly called "immune serum globulin," ISF, or "gamma globulin") produced in the United States contains antibodies against the hepatitis A virus (anti-HAV) and the hepatitis B surface antigen (anti-HBs). Tests of IG lots prepared since 1977 indicate that both types of antibody have uniformly been present. Hepatitis B immune globulin (HBIG) is an IG prepared from plasma containing high titers of anti-HBs.

Neither IG or HBIG commercially available in the United States transmits hepatitis or other viral infections. There is no evidence that the causative agent of AIDS (human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV)) has been transmitted by IG or HBIG (4).

Serious adverse effects from immune globulins administered as recommended have been exceedingly rare. Standard immune globulins are prepared for intramuscular use and should not be given intravenously. Two preparations for intravenous use in immunodeficient and other selected patients have recently become available in the United States but are not recommended for hepatitis prophylaxis. Immune globulins are not contraindicated for pregnant women.

HEPATITIS A

Hepatitis A is caused by the hepatitis A virus (HAV), a 27-nm ribonucleic acid (RNA) agent that is a member of the picornavirus family. The illness caused by HAV characteristically has an abrupt onset with fever, malaise, anorexia, nausea, abdominal discomfort, and jaundice. Severity is related to age. In children, most infections are asymptomatic, and illness is usually not accompanied by jaundice. Most infected adults become symptomatically ill with jaundice. Fatality among reported cases is infrequent (about 0.6%).

Hepatitis A is primarily transmitted by person-to-person contact, generally through fecal contamination. Transmission is facilitated by poor personal hygiene, poor sanitation, and intimate (intrahousehold or sexual) contact. Common-source epidemics from contaminated food and water also occur. Sharing utensils or cigarettes or kissing are not believed to transmit the infection.

The incubation period of hepatitis A is 15-50 days (average 28-30). High concentrations of HAV (10^8 particles/g) are found in stools of infected persons. Fecal virus excretion reaches its highest concentration late in the incubation period and early in the prodromal phase of illness, and diminishes rapidly once jaundice appears. Greatest infectivity is during the 2-week period immediately before the onset of jaundice. Viremia is of short duration; virus has not been found in urine or other body fluids. A chronic carrier state with HAV in blood or feces has not been demonstrated. Transmission of HAV by blood transfusion has occurred but is rare.

Postexposure Prophylaxis. A serologic test for the diagnosis of acute hepatitis A is now widely available. Since only 38% of acute hepatitis cases in the United States result from hepatitis A, serologic confirmation of hepatitis A in the index case is recommended before treatment of contacts. Serologic screening of contacts for anti-HAV before giving IG is not recommended because screening is more costly than IG and would delay its administration.

IG should be given as soon as possible after exposure; giving IG more than 2 weeks after exposure is not indicated.

Specific recommendations for IG prophylaxis of hepatitis A depend on the nature of the HAV exposure:

1. Close personal contact. IG is recommended for all household and sexual contacts of persons with hepatitis A.
2. Day-care centers. Day-care facilities with children in diapers can be important settings for HAV transmission (10-12). IG should be administered to all staff and attendees of day-care centers or homes if: (a) one or more hepatitis A cases are recognized among children or employees; or (b) cases are recognized in two or more households of center attendees. When an outbreak (hepatitis cases in three or more families) occurs, IG should also be considered for members of households whose diapered children attend. In centers not enrolling children in diapers, IG need only be given to classroom contacts of an index case.
3. Schools. Contact at elementary and secondary schools is usually not an important means of transmitting hepatitis. A routine administration of IG is not indicated for pupils and teachers in contact with a patient. However, when epidemiologic study clearly shows the existence of a school- or classroom-centered outbreak, IG may be given to those who have close personal contact with patients.
4. Institutions for custodial care. Living conditions in some institutions, such as prisons and facilities for the developmentally disabled, favor transmission of hepatitis A. When outbreaks occur, giving IG to residents and staff who have close contact with patients with hepatitis A may reduce the spread of disease. Depending on the epidemiologic circumstances, prophylaxis can be limited in extent or can involve the entire institution.
5. Hospitals. Routine IG prophylaxis for hospital personnel is not indicated. Rather, sound hygenic practices should be emphasized. Staff education should point out the risk of exposure to hepatitis A and emphasize precautions regarding direct contact with potentially infective materials (13). Outbreaks of hepatitis A among hospital staff occur occasionally, usually in association with an unsuspected index patient who is fecally incontinent. Large outbreaks have occurred among staff and family contacts of infected infants in neonatal intensive-care units. In outbreaks, prophylaxis of persons exposed to feces of infected patients may be indicated.
6. Offices and factories. Routine IG administration is not indicated under the usual office or factory conditions for persons exposed to a fellow worker with hepatitis A. Experience shows that casual contact in the work setting does not result in virus transmission.
7. Common-source exposure. IG might be effective in preventing foodborne or waterborne hepatitis A if exposure is recognized in time. However, IG is not recommended for persons exposed to a common source of hepatitis infection after cases have begun to occur in those exposed, since the 2-week period during which IG is effective will have been exceeded.

   If a food handler is diagnosed as having hepatitis A, common-source transmission is possible but uncommon. IG should be administered to other foodhandlers but is usually not recommended for patrons. However, IG administration to patrons may be considered if (a) the infected person is directly involved in handling, without gloves, foods that will not be cooked before they are eaten; (b) the hygenic practices of the foodhandler are deficient; and (c) patrons can be identified and treated within 2 weeks of exposure. Situations where repeated exposures may have occurred, such as in institutional cafeterias, may warrant stronger consideration of IG use.

For postexposure IG prophylaxis, a single intramuscular dose of 0.02 ml/kg is recommended.

HEPATITIS B

Hepatitis B virus (HBV) infection is a major cause of acute and chronic hepatitis, cirrhosis, and primary hepatocellular carcinoma worldwide. The frequency of HBV infection and patterns of transmission vary markedly in different parts of the world. In the United States, Western Europe and Australia, it is a disease of low endemicity, with only 0.1%-0.5% of the population being virus carriers and infection occurring primarily during adulthood. In contrast, HBV infection is highly endemic in China and Southeast Asia, sub-Saharan Africa, most Pacific islands, and the Amazon Basin; in these areas 5%-15% of the population carry the virus, and most persons acquire infection at birth or during childhood. In other parts of the world, HBV is moderately endemic, and 1%-4% of persons are HBV carriers. Recommendations for prophylaxis of hepatitis B will vary in accordance with local patterns of HBV transmission. The recommendations that follow are intended for use in the United States.

Hepatitis B infection is caused by the HBV, a 42-nm, double-shelled deoxyribonucleic acid infection. HBsAg, formerly called "Australia antigen" or "hepatitis-associated antigen," is found on the surface of the virus and on accompanying 22nm spherical and tubular forms. HBsAg can be identified in serum 30-60 days after exposure to HBV and persists for variable periods. The various subtypes (adr, adw, ayw, ayr) of HBsAg provide useful epidemiologic markers. Antibody against HBsAg (anti-HBs) develops after a resolved infection and is responsible for long-term immunity. Anti-HBc, the antibody to the core antigen (an internal component of the virus), develops in all HBV infections and persists indefinitely. IgM anti-HBc appears early in infection and persists for 6 or more months; it is a reliable marker of acute or recent HBV infection. The hepatitis B e antigen (HBeAg) is a third antigen, presence of which correlates with HBV replication and high infectivity. Antibody to HBeAg (anti-HBe) develops in most HBV infections and correlates with lower infectivity.

The onset of acute hepatitis B is generally insidious. Clinical symptoms and signs include various combinations of anorexia, malaise, nausea, vomiting, abdominal pain, and jaundice. Skin rashes, arthralgias, and arthritis can also occur. Overall fatality rates for reported cases generally do not exceed 2%. The incubation period of hepatitis B is long -- 45-60 days (average 60-120).

Hepatitis B Prophylaxis. Two types of products are available for prophylaxis against hepatitis B. Hepatitis B vaccine, licensed in 1981, provides active immunization against HBV infection, and its use is recommended for both pre- and postexposure prophylaxis. IG products provide temporary, passive protection and are indicated only in certain postexposure settings.

IG and HBIG. IG and HBIG contain different amounts of anti-HBs. IG is prepared from plasma that is not preselected for anti-HBs content. Since 1977, all lots tested have contained anti-HBs at a titer of at least 1:100 by radioimmunoassay (RIA). HBIG is prepared from plasma preselected for high-titer anti-HBs. In the United States, HBIG has an anti-HBs titer of higher than 1:100,000 by RIA. There is no evidence that the causative agent of AIDS (HTLV-III/LAV) has been transmitted by IG or HBIG (4).

Preexposure vaccination. Persons at substantial risk of acquiring HBV infection who are demonstrated or judged likely to be susceptible should be vaccinated. They include:

1. Health-care workers. The risk of health-care workers acquiring HBC infection depends on the frequency of exposure to blood or blood products and on the frequency of needlesticks. These risks vary during the training and working career of each individual but are often highest during the professional training period. For this reason, it is recommended that vaccination be completed during training in schools of medicine, dentistry, nursing, laboratory technology, and other allied health professions.

   The risk of HBV infection for hospital personnel can very both among hospitals and within hospitals. In developing specific immunization strategies, hospitals should use available published data about the risk of infection (22-24) and may wish to evaluate their own clinical and institutional experience with hepatitis B. Studies in urban centers have indicated that occupational groups with frequent exposure to blood and/or needles have the highest risk of acquiring HBV infection, including (but not limited to) the following groups: medical technologists, operating room staff, phlebotomists and intravenous therapy nurses, surgeons and pathologists, and oncology and dialysis unit staff. Groups shown to be at increased risk in some hospitals include: emergency room staff, nursing personnel, and staff physicians.

   Other health-care workers based outside hospitals who have frequent contact with blood or blood products are also at increased risk of acquiring HBV infection. These include (but are not limited to): dental professionals (dentists, oral surgeons, dental hygienists), laboratory and blood bank technicians, dialysis center staff, emergency medical technicians, and morticians.
2. Clients and staff of institutions for the mentally retarded. Susceptible clients and staff who work closely with clients of institutions for the mentally retarded should be vaccinated. Risks for staff are comparable to those for health-care personnel in other high-risk environments. However, the risk in institutional environments is associated, not only with blood exposure, but also with bites and contact with skin lesions and other infective secretions. Susceptible clients and staff who live or work in smaller (group) residential settings with known HBV carriers should also receive hepatitis B vaccine.
3. Hemodialysis patients. Numerous studies have established the high risk of HBV transmission in hemodialysis units. Although recent data have shown not only a decrease in the rate of HBV infection in hemodialysis units but also a lower vaccine efficacy in these patients, vaccination is recommended for susceptible patients. Environmental control measures and regular serologic screening (based on immune status) of patients should be maintained.
4. Homosexually active men. Susceptible homosexually active men should be vaccinated regardless of their ages or duration of their homosexual practices. It is important to vaccinate persons as soon as possible after their homosexual activity begins. Homosexually active women are not at increased of sexually transmitted HBV infection.
5. Users of illicit injectable drugs. All users of injectable drugs who are susceptible to HBV should be vaccinated as early as possible after their drug use begins.

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MONTANA MORBIDITY REPORT

Volume: 9:9 Month of: AUGUST 1985

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6. Recipients of certain blood products. Patients with clotting disorders who receive clotting factor concentrates have an elevated risk of acquiring HBV infection. Vaccination is recommended for these persons and should be initiated at the time their specific clotting disorder is identified. Screening is recommended for patients who have already received multiple infusions of these products.
7. Household and sexual contacts of HBV carriers. Household contacts of HBV carriers are at high risk of acquiring HBV infection. Sexual contacts appear to be a greatest risk. When HBV carriers are identified through routine screening of donated blood, diagnostic testing in hospitals, prenatal screening, screening of refugees, or other screening programs, they should be notified of their status and their susceptible household contacts vaccinated.
   Families accepting orphans or unaccompanied minors from countries of high HBV endemicity should have the child screened for HBsAg, and if positive, family members should be vaccinated.
8. Other contacts of HBV carriers. Persons in casual contact with carriers at schools, offices, etc., are at minimal risk of acquiring HBV infection, and vaccine is not routinely recommended for them. However, classroom contacts of deinstitutionalized mentally retarded HBV carriers who behave aggressively or have special medical problems that increase the risk of exposure to their blood or serous secretions may be at risk. In such situations, vaccine may be offered to classroom contacts.
9. Special high-risk populations. Some American populations, such as Alaskan Eskimos, native pacific islanders, and immigrants and refugees from areas with highly endemic disease (particularly eastern Asia and sub-Saharan Africa) have high HBV infection rates. Depending on specific epidemiologic and public health considerations, more extensive vaccination programs should be considered.
10. Inmates of long-term correctional facilities. The prison environment may provide a favorable setting for the transmission of HBV because of frequent use of illicit injectable drugs and homosexual practices. Moreover, it provides an access point for vaccination of parenteral drug abusers. Prison officials should consider undertaking screening and vaccination programs directed at those who abuse drugs before or while in prison.
11. Heterosexually active persons. Heterosexually active persons with multiple sexual partners are at increased risk of acquiring HBV infection; risk increases with increasing sexual activity. Vaccination should be considered for persons who present for treatment of sexually transmitted diseases and who have histories of sexual activity with multiple partners.
12. International travelers. Vaccination should be considered for persons who plan to reside more than 6 months in areas with high levels of endemic HBV and who will have close contact with the local population. Vaccination should also be considered for short-term travelers who are likely to have contact with blood from or sexual contact with residents of areas with high levels of endemic disease. Hepatitis B vaccination of travelers ideally should begin 6 months before travel in order to complete the full vaccine series; however, a partial series will offer some protection against HDV infection.

Postexposure prophylaxis for hepatitis B. Prophylactic treatment to prevent hepatitis B infection after exposure to HBV should be considered in the following situations: perinatal exposure of an infant born to an HBsAg-positive mother; accidental percutaneous or permucosal exposure to HBsAg-positive blood; or sexual exposure to an HBsAg-positive person.

Recent studies have established the relative efficacies of immune globulins and/or hepatitis B vaccine in various exposure situations. For perinatal exposure to an HBsAg-positive, HBeAg-positive mother, a regimen combining one dose of HBIG at birth with the hepatitis B vaccine series started soon after birth is 85%-90% effective in preventing development of the HBV carrier state (25, 27). Regimens involving either multiple doses of HBIG alone, or the vaccine series alone, have 70%-75% efficacy, while a single dose of HBIG alone has only 50% efficacy (28).

For accidental percutaneous exposure or sexual exposure, only regimens including HBIG and/or IG have been studied. A regimen of two HBIG doses, one given after exposure and one a month later; is about 75% effective in preventing hepatitis B following percutaneous exposure; a single dose of HBIG has similar efficacy when used following sexual exposure (29-31). IG may have some effect in preventing clinical hepatitis B following percutaneous exposures and can be considered as an alternative to HBIG when it is not possible to obtain HBIG.

Recommendations on postexposure prophylaxis are based on the efficacy data discussed above and on the likelihood of future HBV exposure of the person requiring treatment. In perinatal exposure and percutaneous exposure of high-risk health-care personnel, a regimen combining HBIG with hepatitis B vaccine will provide both short- and long-term protection, will be less costly than the two-dose HBIG treatment alone, and is the treatment of choice.

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AUGUST 1985	TOTAL TO DATE 19 83	TOTAL TO DATE 19 84	TOTAL TO DATE 19 85	MONTHLY TOTAL 19 83	MONTHLY TOTAL 19 84	MONTHLY TOTAL 19 85
ASEPTIC MENINGITIS	2	15	2	2	5	2
ENCEPHALITIS	3	0	0	0	0	0
GIARDIA	3	157	66	0	13	9
HEPATITIS A	18	98	55	3	30	3
HEPATITIS B	17	18	21	8	6	8
MEASLES	0	0	161	0	0	0
MENING. DISEASE	0	2	4	0	0	0
MUMPS	0	7	7	0	2	1
PERTUSSIS	1	19	8	0	2	2
RABIES ANIMALS	1	86	138	0	12	11
RUBELLA	0	4	0	0	0	0
SALMONELLA	1	119	20	0	40	29
SHIGELLA	1	12	36	0	10	6
TUBERCULOSIS	1	20	31	0	6	2
GONORRHEA	55	200	383	3	92	104

DISTRICT 12: Silver Bow; Powell; Madison; Granite; Deer Lodge; Beaverhead
DIST 11: Ravalli; Missoula; Mineral
DISTRICT 10: Sanders; Lincoln; Lake; Flathead
DIST. 9: Meagher; Park; Gallatin
DIST 8: Broadwater; Jefferson; Lewis & Clark
DISTRICT 7: Yellowstone; Sweet Grass; Stillwater; Carbon; Big Horn
DISTRICT 6: Wheatland; Petroleum; Musselshell; Judith Basin; Golden Valley
DISTRICT 5: Fergus; Teton; Pondera; Glacier; Chouteau; Cascade
DIST. 4: Liberty; Hill; Blaine
DISTRICT 3: Treasure; Hobbud; Powder River; Fallon; Custer; Carter
DISTRICT 2: Wibaux; Richland; Prairie; McCone; Garfield; Dawson
DISTRICT 1: Valley; Sheridan; Roosevelt; Phillips; Daniels

DELAYED REPORTS Tuberculosis: Delete 1 case in Valley County.

OTHER DISEASES Amebiasis: Valley,1. Campylobacter: Cascade,2; Gallatin,1; Lake,1; Musselshell,1; Roosevelt,1; Valley,1. Hepatitis, unspecified: Missoula,1; Yellowstone,1. Leptospirosis: Park,1. Cytomegalovirus: Yellowstone,1. Guillian Barre' Syndrome: Cascade,1. Primary Syphilis: Cascade,1. Secondary Syphilis: Cascade,1.

APPLIED EPIDEMIOLOGY COURSE

The Centers for Disease Control and Montana State Department of Health & Environmental Sciences will present the course, Applied Epidemiology (#4440-6), at the Cogswell Building in Helena, Montana, December 4-13, 1985. Applied Epidemiology is a course designed to provide health professionals with the skills and knowledge to perform the steps in a systematic epidemiology surveillance and investigation system. The course includes the following modules:

1) Introduction to Applied Epidemiology
2) Organizing and Analyzing Surveillance Data
3) Identifying the Potential for Disease Occurrence
4) Reporting the Potential for Occurrence of Disease
5) Beginning the Investigation
6) Developing Case Investigation Forms
7) Preventing Transmission from Cases and Contacts
8) Formulating Case Definitions and Identifying Cases for Analysis
9) Characterizing the Multiple-Case Outbreak
10) Formulating and Testing Hypotheses
11) Controlling the Source of the Etiologic Agent
12) Analyzing the Effectiveness of Control Efforts
13) Reporting the Results of Case Investigations
14) Preparing Summary Surveillance Reports

The CDC homestudy course, Principles of Epidemiology (#3030-G), should be completed prior to attending the Applied Epidemiology course. This course can be obtained by contacting Centers for Professional Development and Training, Centers for Disease Control, Atlanta, Georgia 30333, (404) 262-6677.

The format for the Applied Epidemiology course is Criterion-Referenced Instruction (CRI). It is self-paced instruction designed to accomplish specified objectives which describe the level of competence a student must achieve. The duration of the course is regulated by the learner's demonstrated competence, but usually requires most of the 8 days allowed.

The course managers are trained in a manner similar to the CDC course managers and the references are the same as those used at CDC. Standardization of content and quality of the course is assured whether the learner participates in the Atlanta course or one at any other site in the nation.

Tuition is not charged to employees of State and local health agencies. For other applicants, tuition is $224. Payment must be made prior to the course beginning.

In order to plan for the course, please contact Judy Gedrose at 444-5580 if you plan to attend the course. Registration and the course begin at 8:00 a.m., December 4, 1985. Women attending may wish to check on lodging at the YWCA, 501 N. Park, Helena, MT 59601, 443-9771. The Helena Area Chamber of Commerce has a listing of the names and rates of local hotels and motels. This can be obtained by calling 442-4120.

AIDS Task Force

Montana State Department of Health and Environmental Sciences has formed an AIDS Task Force. A four-member medical advisory committee composed of infectious disease specialists, Ron Smith, M.D., Billings; J. Myron Winship, M.D., Missoula; John Pullman, M.D. and James Silva, D.D.S., Butte; will augment the departmental task force. Recommendations for policies concerning the care and follow-up of AIDS patients and HTLV-III positive individuals are forth-coming from the task force. Task force members will also be available for presenting educational offerings upon request.

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Volume: 9:10 Month of: SEPTEMBER 1985

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S 312.2 H2m v.9&10 Sept.1985

SEPTEMBER 1985		ASEPTIC MENINGITIS	ENCEPHALITIS	GIARDIA	HEPATITIS A	HEPATITIS B	MEASLES	MENING. DISEASE	MUMPS	PERTUSSIS	RABIES, ANIMALS	RUBELLA	SALMONELLA	SHIGELLA	TUBERCULOSIS	GONORRHEA
DISTRICT 1	Daniels										1					
	Phillips			1												
	Roosevelt			2	1									2		5
	Sheridan										4					
	Valley										1					
DISTRICT 2	Dawson				1						1					
	Garfield															
	McCone															
	Prairie															
	Richland															
	Wibaux										2					
DISTRICT 3	Carter										3					
	Custer										7					
	Fallon															
	Powder River										2					
	Rosebud										1					2
	Treasure															
DIST. 4	Blaine												1			2
	Hill			2	7	1										3
	Liberty			2												
DISTRICT 5	Cascade	1		3		4										6
	Chouteau															
	Glacier			1	5	2				1			1			8
	Pondera										1					
	Teton															
	Toole															
DISTRICT 6	Fergus															
	Golden Valley															
	Judith Basin															
	Musselshell										1					
	Petroleum															
	Wheatland															
DISTRICT 7	Big Horn															4
	Carbon															
	Stillwater			1												
	Sweet Grass															
	Yellowstone			2	2	2					1			1		20
DIST. 8	Broadwater															
	Jefferson															
	Lewis & Clark			4		1										3
DIST. 9	Gallatin			3		1										2
	Meagher															
	Park					1										
DISTRICT 10	Flathead	1		1	2	5			1				6			1
	Lake			1												2
	Lincoln							1								
	Sanders				1											1
DIST. 11	Mineral															3
	Missoula												1			8
	Ravalli			1												1
DISTRICT 12	Beaverhead			1												1
	Deer Lodge															
	Granite															
	Madison															
	Powell															
	Silver Bow	1														
MONTHLY TOTAL	19 85	3	0	25	19	17	0	1	1	1	25	0	9	3	0	72
	19 84	9	0	13	15	2	0	0	0	0	9	0	11	2	3	81
	19 83	2	2	31	3	1	0	1	2	0	5	2	27	3	7	95
TOTAL TO DATE	19 85	12	0	121	74	38	141	5	8	9	163	0	79	49	41	556
	19 84	26	0	79	113	20	0	2	7	19	100	0	51	12	23	790
	19 83	5	2	188	21	18	0	1	4	1	91	6	146	16	47	760

DELAYED REPORTS:

OTHER DISEASES: Bacterial Meningitis: Ylstn,1. Campylobacter: Cascade,4; Flathead,2; Msla,2. Hepatitis,Non-A,Non-B: Park,1. Hepatitis,unspec Cascade,1; Gallatin,1. Psittacosis: Missoula,1. Syphilis, Primary: Missoula,1.

INFLUENZA PREVENTION

Judith Gedrose, RN, MN, State Epidemiologist

The Influenza season is quickly approaching. A protective response following vaccination takes about two weeks. Hopefully, 1985-86 influenza vaccine containing A/Chile/83 (H_1N_1), A/Phillipines/82 (H_3N_2) and B/USSR/83 hemagglutinin antigens in each 0.5 ml dose have been given. Offering vaccine to healthy adults when an influenza epidemic begins could lessen the impact of the epidemic.

Recommendations from a CDC-organized symposium, held April 20-25, 1985 in Keystone, Colorado, convey a new perspective in considering influenza prevention campaigns. Reports of the symposium reflect a need for more aggressive prevention programs.[1] With information taken from death certificates, Montana had 19 influenza deaths in 1984.[2] The exact number of cases occurring for the year is not known, because influenza is not reportable by individual case, but by number only when an outbreak occurs.

Recommendations have been made to move influenza vaccination more into the realm of a necessity than its present optional status. It is suggested an approved influenza vaccination program might be part of the licensing requirement for nursing homes and/or other institutions. It is recommended that amantadine be given to lessen the severity of community and institutional outbreaks.

Children suffer high morbidity from influenza. Annual immunization of children who are household contacts of high-risk individuals should be considered. This strengthens the current ACIP recommendations that children with chronic health conditions receive yearly influenza vaccination. Children with reactive airway disease should be vaccinated.

Healthy adults who provide essential services or who work with persons at high risk of influenza-related mortality should be immunized to reduce the chance the high-risk will be infected. Employee health programs in hospitals and nursing homes should consider the cost benefits associated with prevention of employee absenteeism compared to the cost of providing the vaccine.

Pregnant women whose third trimester will be occurring between October and March should be considered for receipt of the influenza vaccine. More study regarding the benefits of this are indicated, but it is hypothesized that both mother and baby would be better protected during a vulnerable time, if immunized.

Influenza is spread by direct contact via droplets released when coughing, sneezing or simply talking. The virus may persist for hours in dried mucous. Diseases spread in such a manner are of most consequence in populations where many persons live in limited space. Therefore, residents of dormitories in schools or military installations should be considered for vaccination regardless of age.

It is hypothesized that mortality and morbidity related to influenza can be reduced by more aggressive prevention and control programs. The preceding has outlined some specific recommendations for implementing more agressive programs.

References:

1. Morbidity and Mortality Weekly Report, October 18, 1985. pp. 639-642.
2. 1984 Vital Statistics, Montana, Bureau of Records and Statistics, State Department of Health and Environmental Sciences.

- -

AIDS and HTLV-III Positivity Reporting

Emergency rules are once again in effect for reporting of AIDS cases and laboratory tests for HTLV-III antibody or virus. AIDS cases are reportable to the local and State health departments upon their diagnosis. The Confidential Case Card and/or a telephone call can be utilized for AIDS case reporting.

Human T-Lymphotropic Virus-III testing is reportable. The Department has developed a form to be submitted each month for the preceding month by laboratories and physicians. The reporters are asked to report HTLV-III positive tests on a newly developed case card, specifically for HTLV-III positive tests. The rules also require a laboratory to submit a confirmation specimen to MDHES microbiology laboratory when the local lab gets a positive result.

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Volume: 9:11 Month of: OCTOBER 1985

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OCTOBER 1985		ASEPTIC MENINGITIS	ENCEPHALITIS	GIARDIA	HEPATITIS A	HEPATITIS B	MEASLES	MENING. DISEASE	MUMPS	PERTUSSIS	RABIES, ANIMALS	RUBELLA	SALMONELLA	SHIGELLA	TUBERCULOSIS	GONORRHEA
DISTRICT 1	Daniels										2					
	Phillips			1												
	Roosevelt				2						3			1		15
	Sheridan										3		1			
	Valley										1		1			
DISTRICT 2	Dawson										8					
	Garfield										3					
	McCone															
	Prairie															
	Richland										2					
	Wibaux															
DISTRICT 3	Carter										3					
	Custer															
	Fallon										1					
	Powder River										7					
	Rosebud										1				2	5
	Treasure										2					
DIST. 4	Blaine															
	Hill			3		1								1		
	Liberty															
DISTRICT 5	Cascade					3		1								6
	Chouteau															
	Glacier			1	2								1		1	13
	Pondera										2					
	Teton															
	Toole															
DISTRICT 6	Fergus										3			1		
	Golden Valley															
	Judith Basin															
	Musselshell															
	Petroleum															
	Wheatland															
DISTRICT 7	Big Horn			1	1	1									1	2
	Carbon															
	Stillwater															
	Sweet Grass															
	Yellowstone			1					2							20
DIST. 8	Broadwater															
	Jefferson															
	Lewis & Clark			2									1			2
DIST. 9	Gallatin			5									1			5
	Meagher															
	Park															1
DISTRICT 10	Flathead			7	1	2										2
	Lake			1	2											5
	Lincoln				1											
	Sanders															
DIST. 11	Mineral															
	Missoula			4	2	1									1	18
	Ravalli				1											1
DISTRICT 12	Beaverhead			1												
	Deer Lodge			4												
	Granite															
	Madison															
	Powell															
	Silver Bow			1												1
MONTHLY TOTAL	19 85	0	0	32	12	8	0	1	2	0	41	0	5	3	5	96
	19 84	0	0	33	13	4	0	0	1	0	7	0	7	1	0	75
	19 83	3	0	16	1	0	3	0	3	0	11	0	10	0	0	98
TOTAL TO DATE	19 85	12	0	153	86	46	141	6	10	9	204	0	84	52	46	652
	19 84	26	0	112	126	24	0	2	8	19	107	0	58	13	22	865
	19 83	8	2	204	22	18	3	1	7	1	102	6	156	16	42	858

Tuberculosis Update: We now have 46 cases of TB in Montana for 1985. Due to reporting delays as well as reporting from treatment centers not in patient's home counties, the following changes are necessary: Delete 1 in Blaine, Cascade, Custer, Deer Lodge, & Lewis & Clark Counties. Add 1 in Big Horn, Jefferson, Lake, Phillips, and Sheridan Counties.

OTHER DISEASES: Amebiasis: Gallatin,1. Bacterial meningitis: Blaine,1; Lewis & Clark,1; Mineral,1; Missoula,1; Ravalli,1; Yellowstone,1. Campylobacter: Flathead,1; Gallatin,1; Hill,1; Lincoln,1. Hepatitis, unspecified: Lewis & Clark,1. Psittacosis: Missoula,1.

OVERVIEW AND MAGNITUDE OF THE PROBLEM OF NONCOMPLIANCE*

In recent years, there has been an increasing awareness of, and concern about, the problem of noncompliance with prescribed antituberculosis chemotherapy. The following provides a brief overview of what is known about compliance and offers suggestions for detecting and dealing with noncompliant behavior as it relates to treatment of tuberculosis and preventive therapy for tuberculosis infection. Some of the material presented was derived from an excellent book edited by Haynes, Taylor, and Sackett entitled "Compliance and Health Care" which readers may wish to consult for a more detailed and thorough review of the subject.

Compliance is defined as the extent to which a person's health-related behaviors, i.e., taking medication, keeping appointments, etc., coincide with medical advice. Those who object to the term "compliance" because of its judgmental connotation, may wish to substitute the word "adherence" wherever "compliance" appears. Both terms are intended to be nonjudgmental; that is, there is no implication of blame.

In the past, physicians were taught that it was their responsibility to diagnose and prescribe appropriate treatment for a disease. The patient was expected to assume responsibility for complying with the physician's advice. According to this view, if the patient failed to comply, he/she simply reaped the consequences (by not getting better, getting worse, dying, or if he/she has a communicable disease, being quarantined) of this "noncompliant" behavior. Recently, health care providers have begun to approach the issue of compliance from a fresh viewpoint. We recognize that all of us selectively choose what we wish to do and wish not to do. Generally, we tend to be more "compliant" with the health care provider's prescription if we (1) perceive it is important, (2) feel capable of performing the task, (3) perceive benefits from performing the task, and (4) can easily assimilate the task into our daily lifestyle. Therefore, the responsibility of dealing with the problem of noncompliance is not solely the patient's. The effective heatlh care provider must share that responsibility by: (1) Providing the patient with knowledge and skills necessary for compliant behavior; (2) maintaining an awareness of the "signs and symptoms" of noncompliance; and (3) helping the patient identify and remove obstacles to compliant behavior. In addition, public health officials are responsible to their constituents for assuring that infectious cases of tuberculosis are brought under treatment and rendered noninfectious.

Noncompliance is a protean feature of all self-administered therapeutic regimens, regardless of the medical condition(s) for which they are prescribed. Scheduled appointments that are initiated by health care providers are kept about 50 percent of the time. Compliance with medication prescribed over many weeks or months (as is the case with antituberculosis drugs) also averages about 50 percent.

It has been repeatedly confirmed that noncompliance is a major cause of relapse in tuberculosis. Reports submitted to the Division of Tuberculosis Control, Centers for Disease Control (CDC), by tuberculosis control programs throughout the United States indicate that about 20 percent of tuberculosis patients fail to complete the therapy within a 24-month period. In some programs, the figure is as high as 50 percent.

Compliance with preventive therapy is also a problem. According to program reports submitted to CDC, 20 to 25 percent of the persons prescribed preventive therapy in the United States fail to complete treatment within 1 year. In an isoniazid (INH)-related hepatitis surveillance program conducted during the early 1970's, patients were prescribed the usual 12-month course of INH. About 64 percent of them picked up 3 consecutive monthly supplies of INH, 41 percent picked up 6 consecutive monthly supplies, but only 22 percent picked up all 12 consecutive monthly supplies. Thus, data from several sources indicate that noncompliance is a major problem in tuberculosis control.

* Improving Patient Compliance in Tuberculosis Treatment Programs, USDHHS, 1985.

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Volume: 9:12 **Month of:** NOVEMBER 1985

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NOVEMBER 1985		ASEPTIC MENINGITIS	ENCEPHALITIS	GIARDIA	HEPATITIS A	HEPATITIS B	MEASLES	MENING. DISEASE	MUMPS	PERTUSSIS	RABIES, ANIMALS	RUBELLA	SALMONELLA	SHIGELLA	TUBERCULOSIS	GONORRHEA
DISTRICT 1	Daniels										3					
	Phillips															
	Roosevelt												1			5
	Sheridan										2					
	Valley										2					
DISTRICT 2	Dawson										1					
	Garfield															
	McCone										2					
	Prairie															
	Richland										1					
	Wibaux										1					
DISTRICT 3	Carter										2					
	Custer										2					2
	Fallon															
	Powder River										1					
	Rosebud															8
	Treasure															
DIST. 4	Blaine															
	Hill															6
	Liberty															
DISTRICT 5	Cascade			1	1	1					1					6
	Chouteau															
	Glacier			3	2											2
	Pondera										2					1
	Teton															
	Toole															2
DISTRICT 6	Fergus										1					
	Golden Valley															
	Judith Basin															
	Musselshell															
	Petroleum															
	Wheatland															
DISTRICT 7	Big Horn										1					3
	Carbon															
	Stillwater			1												
	Sweet Grass															1
	Yellowstone			2	2	1			1							24
DIST. 8	Broadwater															
	Jefferson															
	Lewis & Clark					1							1			3
DIST. 9	Gallatin			1												8
	Meagher															
	Park															1
DISTRICT 10	Flathead			2												1
	Lake				1											1
	Lincoln				1											
	Sanders															
DIST. 11	Mineral				1											
	Missoula				1											
	Ravalli															1
DISTRICT 12	Beaverhead															
	Deer Lodge			1												
	Granite															
	Madison												1			
	Powell										2					1
	Silver Bow															1
MONTHLY TOTAL	19 85	0	0	11	9	3	0	0	1	0	24	0	3	0	0	77
	19 84	0	0	17	26	1	0	0	2	0	13	0	1	0	6	69
	19 83	0	0	19	3	1	1	0	2	1	6	0	3	1	0	132
TOTAL TO DATE	19 85	12	0	164	95	49	141	6	11	9	228	0	87	52	46	729
	19 84	26	0	129	152	25	0	2	10	19	120	0	59	13	28	934
	19 83	8	2	223	25	19	4	1	9	2	108	6	159	17	42	990

DELAYED REPORTS: October - AIDS: S. Bow,1.

OTHER DISEASES: Bacterial Meningitis: Cascade, 4; Flathead,1; Gallatin,1; Lincoln,1; Missoula, 1; Valley,1. Campylobacter: Flathead,1; Hill,1; L & C,1. Hepatitis, unspecified: Toole,1. Q-fever: S.Bow,1.

MENINGITIS IN MONTANA - 1983-1985

Judith Gedrose, RN, MN,
State Epidemiologist

Much concern has been voiced regarding meningitis in Montana in recent months. Review of data concerning reported meningitis cases through December 12, 1985 compared to 1984 and 1983 indicates an increased incidence of bacterial meningitis this year over both the previous years. Aseptic meningitis cases reported so far this year are one-half the number reported last year, but similar to the number of 1983 cases.

Specifically, Haemophilus influenzae-caused bacterial meningitis case reports have increased; the incidence for this year to date is nearly twice the incidence for 1984 or 1983. (See table.)

DATA CONCERNING REPORTED MENINGITIS
CASES IN MONTANA SINCE JANUARY 1, 1983 - DECEMBER 12, 1985

Type of meningitis	Year	No. of Cases
Meningococcal meningitis	1985	9
	1984	4
	1983	5
Aseptic meningitis	1985	11
	1984	27
	1983	8
Bacterial Meningitis (excluding meningococcal)	1985	30
	1984	16
	1983	17
Haemophilus influenzae	1985	26
	1984	9
	1983	17
Streptococcus pneumoniae	1985	1
	1984	0
	1983	1
Unspecified bacterial	1985	1
	1984	4
	1983	6
Pneumococcal	1985	2
	1984	2
	1983	0
Listeria monocytogenes	1985	0
	1984	1
	1983	0

A four-year study of hospitalized meningitis cases was done in Sedgwick County, Kansas.[1] 391 cases were identified during the period. The crude incidence rate was 27 per 100,000 person years, while the age specific rate for those under 5 years of age was 174 per 100,000 person years. The case fatality rate was 3%. Bacterial organisms were identified in 33% of the cases and approximately one-half of the bacterial cases were infected with Haemophilus influenzae. Increased mortality was seen in children and the elderly and those with concomitant disease.

Because of under-reporting, the impact of meningitis can only be estimated. The Centers for Disease Control reported the incidence of bacterial meningitis at 2.9 per 100,000 person years. This probably only represents 30% of the true number of cases. The Sedgwick County study determined that only 16% of all cases were reported to the public health department.

1. Skoch, Michael and Walling, Anne. Meningitis: Describing the Community Health Problem, American Journal of Public Health, Vol. 75, No. 5, pp 550-551.

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Volume: 9:13 Month of: DECEMBER 1985

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DECEMBER 1985		ASEPTIC MENINGITIS	ENCEPHALITIS	GIARDIA	HEPATITIS A	HEPATITIS B	MEASLES	MENING. DISEASE	MUMPS	PERTUSSIS	RABIES, ANIMALS	RUBELLA	SALMONELLA	SHIGELLA	TUBERCULOSIS	GONORRHEA
DISTRICT 1	Daniels										1					
	Phillips															2
	Roosevelt				7											
	Sheridan										4					
	Valley										1					1
DISTRICT 2	Dawson															
	Garfield															
	McCone															
	Prairie										1				1	
	Richland															
	Wibaux										1					
DISTRICT 3	Carter										3					
	Custer										2					
	Fallon										3					
	Powder River										2					
	Rosebud															1
	Treasure															
DIST. 4	Blaine				1											2
	Hill															1
	Liberty															
DISTRICT 5	Cascade				5			1								13
	Chouteau										1					
	Glacier				1								1		1	7
	Pondera															
	Teton															
	Toole															
DISTRICT 6	Fergus										1					
	Golden Valley															
	Judith Basin															
	Musselshell															
	Petroleum															
	Wheatland															
DISTRICT 7	Big Horn				2											2
	Carbon															
	Stillwater															1
	Sweet Grass															
	Yellowstone			2		1							1			17
DIST. 8	Broadwater															
	Jefferson															
	Lewis & Clark															1
DIST. 9	Gallatin															1
	Meagher															
	Park															
DISTRICT 10	Flathead			3												1
	Lake			1												1
	Lincoln															
	Sanders															
DIST. 11	Mineral				2											
	Missoula				1*	1**										9
	Ravalli			1												
DISTRICT 12	Beaverhead															
	Deer Lodge															
	Granite															
	Madison														1	
	Powell															
	Silver Bow															1
MONTHLY TOTAL	1985	0	0	7	18	1	0	1	0	0	20	0	2	0	3	61
	1984	1	0	9	3	2	0	0	1	1	5	0	3	2	4	101
	1983	0	0	19	2	1	1	0	0	0	7	1	3	2	8	132
TOTAL TO DATE	1985	12	0	171	114	51	141	7	11	9	248	0	89	52	49	790
	1984	27	0	138	155	27	0	2	11	20	125	0	62	15	32	1035
	1983	8	2	242	27	20	5	1	9	2	115	7	162	19	50	1122

DELAYED REPORTS: *Hepatitis A (Oct. 1985) 1 case, Missoula County.
**Hepatitis B (Nov. 1985) 1 case, Missoula County.
Hepatitis, unspecified (Oct. 1985) 1 case, Missoula County.

OTHER DISEASES: Campylobacter - Flathead, 1.

1985 ANNUAL DISEASE SUMMARY

AIDS - 1
Silver Bow, 1

Amebiasis - 2
Gallatin, 1
Valley, 1

Botulism - 0

Chickenpox - 471
Big Horn, 25
Blaine, 2
Cascade, 13
Deer Lodge, 7
Fallon, 3
Flathead, 45
Gallatin, 27
Glacier, 8
Hill, 12
Judith Basin, 2
Lake, 85
Lewis & Clark, 2
Missoula, 34
Pondera, 3
Ravalli, 11
Roosevelt, 1
Yellowstone, 191

Colorado Tick Fever - 7
Beaverhead, 1
Missoula, 2
Park, 1
Ravalli, 3

Coccidiomycosis - 1
Lewis & Clark - 1

Conjunctivitis - 98

Cytomegalovirus - 1
Yellowstone, 1

Diphtheria - 0

Encephalitis - 0

Fifth's Disease - 3
Gallatin, 1
Lake, 2

Guillian-Barre' Syndrome - 1
Cascade, 1

Herpes, genital - 229
Beaverhead, 5
Big Horn, 2
Cascade, 6 (+2 military)
Chouteau, 2
Custer, 3
Dawson, 5
Deer Lodge, 1
Flathead, 45

Herpes, Genital, Cont'd.
Gallatin, 25
Hill, 39
Lake, 7
Lewis & Clark, 48
Lincoln, 1
Madison, 2
Park, 9
Ravalli, 5
Roosevelt, 5
Rosebud, 1
Silver Bow, 10
Valley, 3
Yellowstone, 3

Histoplasmosis - 1
Cascade, 1

Influenza - 230

Legionellosis - 6
Cascade, 2
Missoula, 1
Park, 1
Pondera, 1
Yellowstone, 1

Listeriosis - 1
Yellowstone, 1

Malaria - 0

Measles - 137
Blaine, 1
Gallatin, 1
Glacier, 118
Missoula, 2
Pondera, 4
Powell, 1
Ravalli, 9
Toole, 1

Meningitis, aseptic - 12
Cascade, 2
Deer Lodge, 1
Flathead, 1
Gallatin, 2
Lewis & Clark, 1
Roosevelt, 1
Sheridan, 1
Silver Bow, ?
Yellowstone, 1

Meningitis, Bacterial
Non-HIB - 4
Cascade, 1
Flathead, ?
Lewis & Clark, 1

Mononucleosis, infectious - 140

Mumps - 12
Cascade, 1
Flathead, 1
Gallatin, 1
Lake, 2
Richland, 1
Yellowstone, 6

Mycoplasma - 1
Yellowstone, 1

Pertussis - 10
Fallon, 1
Glacier, 2
Hill, 1
Meagher, 1
Phillips, 1
Ravalli, 1
Yellowstone, 3

Psittacosis - 2
Gallatin, 1
Missoula, 1

Q Fever - 1
Silver Bow, 1

Rocky Mtn. Spotted Fever - 3
Custer, 1
Dawson, 1
Golden Valley, 1

Rubella - 0

Strep Throat & Scarlet Fever
2,165+ statewide

Syphilis - 8
Cascade, 3
1 primary, 1 secondary,
1 early latent 1 year
Deer Lodge, 1 late latent
Lake, 1 secondary
Missoula, 1 primary
Yellowstone, 2 secondary

Toxic Shock Syndrome - 0

Toxoplasmosis - 1
Cascade, 1

Tularemia - 6
Big Horn, 5
Missoula, 1

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1985 ANNUAL DISEASE SUMMARY	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead			5	6							1				1
Big Horn	1		4	34		3	1					1	1	2	2
Blaine		3		18	1	1					14	2	4	5	1
Broadwater				1							1				
Carbon											1				
Carter											5	23			
Cascade	6	2	4	77	4	8	13		2	2	6	2	5	3	3
Chouteau												3			
Custer		1		5						2	9	18		1	3
Daniels												11			
Dawson			1	1		1					1	24			
Deer Lodge	1		7										2		2
Fallon					1						13	11			
Fergus											6	12	1	1	
Flathead	5	1	18	30		4	12	1	2		3		16		1
Gallatin	6	47	26	37	4	2	2		2		3		6		
Garfield												3			
Glacier		4	10	80		11	4				1		8		5
Golden Valley															
Granite				1								1	1		
Hill	2	48	9	29		7	5				5		5	6	4
Jefferson				1											1
Judith Basin												2			
Lake	2	3	5	15	1	12					3		3		1
Lewis & Clark	4	2	15	27	2	5	7		1	1	11	3	4		1
Liberty			4	1											
Lincoln	1		3	1	1	2				1	1	2	1		2
McCone											2	10	1		
Madison			1	1							1		1		1
Meagher															
Mineral				10	1	3									
Missoula	16	1	23	72	5	12	6	1	3	2	6	1	14	1	2
Musselshell	3			2								4			
Park			1	4			1	1							2
Petroleum										1					
Phillips			2	1							1				1
Pondera	1	1		2							8	10			
Powder River											10	44			
Powell				1							7	1			
Prairie												3			1
Ravalli			2	7	1	2					3				
Richland				7						1		5		1	
Roosevelt	1		5	72		36			1		1	5	2	28	2
Rosebud		1	2	38							26	11		2	6
Sanders			2	2		1			1						
Sheridan											11	17	1		1
Silver Bow			7	13	3	3	2			1	3		3		2
Stillwater			2	6											
Sweet Grass				1											
Teton				1											
Toole				2					1			8			
Treasure												2			
Valley	2			1	1	1					6	12	1		1
Wheatland				1											
Wibaux		1										4			
Yellowstone	2	35	16	186	2	5	8	2	2		1	1	9	3	4
TOTAL 1985	53	150	174	794*	28	119	61	5	15	11	170	256	89	53	50
TOTAL 1984	52	75	148	1040*	10	160	26	8	3	2	74	125	61	15	32
TOTAL 1983	42	**	261	1244*	17	33	21	2	16	5	**	123	164	19	47

*Gonococcal disease totals:
1985 includes 14 military
1984 includes 14 military
1983 includes 27 military
**1983 totals not available

NOTE: TOTALS ARE FROM THOSE COUNTIES REPORTING.